

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12528

Reg. Dist. No. 7

1. **WILLATE** corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/cremation permit. File pages 1 and 2 with the remains or prior to burial, cremation.

1. **PLACE OF DEATH**
a. **COUNTY**

Allegany

MARYLAND

b. **CITY OR TOWN** (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. **LENGTH OF STAY IN 1b**

10 yrs

d. **NAME OF HOSPITAL OR INSTITUTION** (If not in hospital, give street address)

Sacred Heart Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution, Residence before admission)

a. **STATE**

Md.

b. **COUNTY**

Allegany

c. **CITY OR TOWN** (If outside corporate limits, write RURAL and give nearest town)

02 Cumberland

d. **STREET ADDRESS**

1221 Baltimore St.

e. **IS RESIDENCE
ON A FARM?**
YES NO

3. **NAME OF
DECEASED**
(Type or print)

First
William

Middle
Henry

Last
Anderson

4. **DATE
OF
DEATH**

Month Dec. 29
Day 19
Year 57

5. **SEX**

Male

6. **COLOR OR RACE**

white

7. **MARRIED** **NEVER MARRIED**

WIDOWED DIVORCED

8. **DATE OF BIRTH**

Sept. 23-1889

9. **AGE (in years
last birthday)**

68 yrs.

10. **IF UNDER 1 YEAR**

Months 0
Days 0
Hours 0
Min. 0

10a. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

10b. **KIND OF BUSINESS OR INDUSTRY**

11. **BIRTHPLACE** (State or foreign country)

12. **CITIZEN OF WHAT COUNTRY?**

retired-Supt. Linde Air Products Co.

Illinois

U.S.A.

13. **FATHER'S NAME**

Henry Anderson

14. **MOTHER'S MAIDEN NAME**

Libby (Unknown)

Address

15. **WAS DECEASED EVER IN U. S. ARMED FORCES?**
(Yes, no, or unknown)

Yes

(If yes, give war or dates of service)

W.W.I

16. **SOCIAL SECURITY NO.**

067-09-5837

17. **INFORMANT**

Hospital records

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.0

DUE TO

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
sudden

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Arteriosclerotic heart disease

?

DUE TO

(c)

Hypertension

over
2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Intertrochanteric fracture of left femur.

19. **WAS AUTOPSY
PERFORMED?**
YES NO

20a. **EXTERNAL CAUSE WAS
PRIMARY** **or CONTRIBUTING**
CAUSE OF DEATH. 903.0

20b. **DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

His cane slipped on linoleum, kitchen floor, fell to floor

20c. **TIME OF INJURY** Month, Day, Year
Hour a. m. p. m. Dec. 3 1957

20d. **INJURY OCCURRED**
While at work Not while at work

20e. **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

Home

Cumberland, Allegany, Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

H. V. Deming M.D.

DATE SIGNED

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER Dec. 30-1957

22a. **BURIAL, CREMATION,
REMOVAL (Specify)**

Burial

22b. **DATE THEREOF**

Dec. 31, 1957

22c. **NAME OF CEMETERY OR CREMATORIUM**

Allegany County Cemetery

22d. **LOCATION (City, town, or county)**

Cumberland, Maryland

(State)

23. **FUNERAL DIRECTOR'S SIGNATURE**

Louis Stein, Inc., Cumberland, Maryland.

ADDRESS

24a. **REC'D BY REGISTRAR**

DATE 31.1957

24b. **REGISTRAR'S SIGNATURE**

J. van Stein, M.D.

BUREAU V. S.

JAN 2 1963

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed by the funeral director. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12524

12529 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 26 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO CUMBERLAND, rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 1 BOWLING GREEN, R.F.D. #5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First URSA	Middle VIRGINIA	Last BANE	4. DATE OF DEATH DECEMBER 17 1957	Month DECEMBER	Day 17	Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1908	9. AGE (In years at birthday) 49 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY W. Md. Railroad Company		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. MD.		
13. FATHER'S NAME THOMAS BANE		14. MOTHER'S MAIDEN NAME CARRIE SIMMON						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell Ca of uterine cervix INTERVAL BETWEEN ONSET AND DEATH 14 mos								
171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 8-9 , 19 56 , to 12-17 , 19 57 , that I last saw the deceased alive on 12-17 , 19 57 , and that death occurred at 3:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 12-18-57								
ACTUAL SIGNATURE <i>Regina W. Bane</i>	M.D.							
PHYSICIAN'S NAME (Type) DR. RALPH BALLIN	Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 20, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Queen's Point Cemetery		22d. LOCATION (City, town, or county) Keyser, West Virginia		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland		ADDRESS 100 Main St., Cumberland, Maryland		24a. REC'D BY REGISTRAR 12-19-1957		24b. REGISTRAR'S SIGNATURE John van Stein, O.D.		

EXERCISE OF DRAFT

BUREAU V. S

DEC 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12525
9

12597 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 185 Bowery St.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
3. NAME OF DECEASED (Type or print) SARAH		4. DATE OF DEATH DEC. 28, 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ann Smedley		14. MOTHER'S MAIDEN NAME Hugh B. Hough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. none	
17. INFORMANT Miss Ann Bender, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for, (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 arterio-sclerotic		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Cardio-vascular disease		(c) 5 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-10 , 19 55 to 12-28 , 19 57 , that I last saw the deceased alive on 12-28 , 19 57 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE H. C. Diehl, M. D.		ADDRESS (Street, city or town, state) W. Main St., Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-57	
22c. NAME OF CEMETERY OR CREMATORIAL Eckhart Cemetery		22d. LOCATION (City, town, or county) Eckhart, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE 12-30-57		24b. REGISTRAR'S SIGNATURE Ms. Nancy H. Ross	

CERTIFICATE OF DEATH

BUREAU V. S

JAN 6 1928

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

12530

12526

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS / 208 Paca St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Arnold	Middle Jesse	Lost	4. DATE OF DEATH	Month Dec.	Day 1	Year 1957
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 20-1903	9. AGE (in years last birthday) 54 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sovel operator*George Construction		10b. KIND OF BUSINESS OR INDUSTRY Co. Elk Garden, W. Va.		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Bennear		14. MOTHER'S MAIDEN NAME Matilda Whitacre						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Leilia		Address F. Bennear, Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pontine hemorrhage				INTERVAL BETWEEN ONSET AND DEATH A few hrs		
443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Hypertension				?		
(c) Cardiac hypertrophy.						?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) H. V. Deming M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 2-1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-4/57		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 3/19/57		24b. REGISTRAR'S SIGNATURE John van Steen, M.D.		
VS. A15ME 5M 2/57								

BUREAU V. S.

EC 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12531

CERTIFICATE OF DEATH

Reg. Dist. No.

12527

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 415 BALTIMORE AVE.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) BRUCE		First	Middle	Lost	4. DATE OF DEATH BENNETT	Month DECEMBER	Day 3	Year 1957
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH JULY 10, 1881	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp. of America		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? Chaneysville USA		
13. FATHER'S NAME JOSEPH BENNETT				14. MOTHER'S MAIDEN NAME ANNA DELL				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 217-10-4991		17. INFORMANT PT'S CHART		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 197X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under: lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Artemas		(County) Pennsylvania
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 12:05 P M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 43 Greene Street, Cumberland, Md.		DATE SIGNED 12/8/57		
ACTUAL SIGNATURE B. M. Schindler		M.D.						
PHYSICIAN'S NAME (Type) B. M. Schindler								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 6, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Fairview Christian Cem.		22d. LOCATION (City, town, or county) Artemas		(State) Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR 7.19.57		24b. REGISTRAR'S SIGNATURE T. J. Hafer, M.D.		

STATE DEPARTMENT OF LABOR - BUREAU OF LABOR

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 11 1957

RECEIVED

FOR STATE
HEALTH DEPT.

11 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with this form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Outside city limits 26:5 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12528

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE I'd. b. COUNTY Allegany								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) - Cumberland		c. LENGTH OF STAY IN lb 15 yrs.								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.P.D. 1 Rowans Addition		d. STREET ADDRESS R.P.D. 1 Rowans Addition								
e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) Charles		First C.	Middle Berry	Last e. DATE OF DEATH Month Dec.	Day 13	Year 1957		
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9-1867		9. AGE (in years last birthday) 90 yrs	10. IF UNDER 1 YEAR Months 12. CITIZEN OF WHAT COUNTRY? U.S.A.	11. IF UNDER 24 HRS Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not reg.) Timber man		10b. KIND OF BUSINESS OR INDUSTRY coal miner		11. BIRTHPLACE (State or foreign country) Flintstone, I'd.		12. MOTHER'S MAIDEN NAME M. Eastman Address (daughter) Blanche Rice, Cumberland, Md.				
13. FATHER'S NAME Samuel K. Berry		14. MOTHER'S MAIDEN NAME M. Eastman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT Coronary occlusion	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) is Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Generalized arteriosclerosis (c) DUE TO	19. INTERVAL BETWEEN ONSET AND DEATH Summer ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE H. V. Denning M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 14-1957		DATE SIGNED				
22a. BURIAL, CREMATION, TOMB REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/57		22c. NAME OF CEMETERY OR CREMATORIAL Oakdale Cem.		22d. LOCATION (City, town, or county) Flintstone, Md. (State)				
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George - Cumberland, Md.		ADDRESS George		24a. REC'D BY REGISTRAR Dec. 16, 1957		24b. REGISTRAR'S SIGNATURE John van Steen, M.D.				

32 hours

DEC

1978

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12532

CERTIFICATE OF DEATH

12529

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 12 HRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,	
3. NAME OF DECEASED (Type or print) MR. FRANK		First R. BLAUL	Middle Last
4. DATE OF DEATH Month DEC. 20		Day 19	Year 57
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/1896
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Investment Broker		10b. KIND OF BUSINESS OR INDUSTRY Securities	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME FREDERICK BLAUL		14. MOTHER'S MAIDEN NAME MARY RALEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214032-3064	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myeloneural Infection, acute		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) Hypertension and arteriosclerotic cardiovascular disease		3 years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1952, to Dec. 1957, that I last saw the deceased alive on Dec. 1957, and that death occurred at 12:10PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Ormer		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 12 Dec. 57	
PHYSICIAN'S NAME (Type) W. Alfred Van Ormer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/1957	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Mausoleum
22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR Date Dec. 23, 1957
			24b. REGISTRAR'S SIGNATURE John van Ormer, M.D.

BUENOS AIRES

DEC 17

BUENOS AIRES

Within corporate limit.

FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with Form PH3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12530

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate lim's, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 201 Baltimore St.		d. STREET ADDRESS 201 Baltimore St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Leo		4. DATE OF DEATH Month Dec. Day 8 Year 1957	
First Middle Last		5. SEX male	
6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Oct. 21-1882	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired brakeman		10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.	
11. BIRTHPLACE (State or foreign country) Meyersdale, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry J. Blough		14. MOTHER'S MAIDEN NAME Mattie Blisel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) no		16. SOCIAL SECURITY NO 705-07-9740	
17. INFORMANT (If yes, give war or dates of service)		Address (son) Bernard Blough, LaVale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH gradual about 5 years.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 9-1957 DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.			
22a. BURIAL/CREMATION/REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1957	
22c. NAME OF CEMETERY OR CREMATORY Sts. Peter & Paul Cem.		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Funeral Home, Cumberland, Maryland.		24a. REC'D BY REGISTRAR DATE 10/1957	
		24b. REGISTRAR'S SIGNATURE <i>Joe Van Shie, M.D.</i>	

BRUNAU V. 8

20. 10. 1957

KEGELVÆD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12534

CERTIFICATE OF DEATH

12531

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN lb 43 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 719 Bedford Street		d. STREET ADDRESS 719 Bedford Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Howard	Middle William	Last Boor
4. DATE OF DEATH	Month December	Day 31	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26 1872
9. AGE (In years last birthday) 85 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg Houses	
11. BIRTHPLACE (State or foreign country) Bedford Valley Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Boor		14. MOTHER'S MAIDEN NAME Margaret Boor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT 714070599A William H. Boor, Cumberland, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Chronic Nephritis (uremia) 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		Influenza, pneumonia 5 days	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-27-57 to 12-31-1957 that I last saw the deceased alive on 12-20-1957, and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mr. J. Williams, M.D., Cumberland, Md. 12/31/57			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 2 1958		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		24a. REC'D BY REGISTRAR DATE 12-31-1957	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE H. H. Kight	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3.00 V. S.

6.7

2.5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12616 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12532

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		X2 Barton	
3. NAME OF DECEASED (Type or print) Cecil		4. DATE OF DEATH Dec. 15 1957	
5. SEX Male		6. COLOR OR RACE white	
7. MARRIED WIDOWED		8. DATE OF BIRTH Sept. 21-1897	
9. AGE, in years last birthday 60 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Baughman Construction Co.		11. BIRTHPLACE (State or foreign country) Garrett Co.	
13. FATHER'S NAME Joseph Broadwater		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4d0.1 DUE TO Coronary occlusion		sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Coronary sclerosis with angina syndrome.		1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or Town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Dec. 16-1957	
DATE SIGNED			
EXAMINER'S NAME (Type) H. V. Deming M.D.		22d. LOCATION (City, town, or county) (State)	
22e. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) <i>burial 12/18/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. View</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>El. Boral - Westernport-mel</i>		24e. REC'D BY REGISTRAR DATE 12-17-57	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>John Kelly</i>	

SCHEAU V. S.

DEC 01 1977

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12535

CERTIFICATE OF DEATH

12533

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE

Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Sacred Heart Hospital

c. LENGTH OF STAY IN lb

4 days

d. STREET ADDRESS

1503 Bedford Street

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)First
JohnMiddle
LLast
Brooks4. DATE
OF
DEATH
12Month
20Day
20Year
19 57

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

68 yrs

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Conductor

10b. KIND OF BUSINESS OR INDUSTRY
B. & O.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

D.C.

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
If yes, give war or date of service)

No

16. SOCIAL SECURITY NO.

705 09 7805

17. INFORMANT

Address

Chart

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)].

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

422.1

DUE TO

Myocardial Degeneration

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

Arteriosclerosis

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 20d. INJURY OCCURRED
p. m. 19 While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 1/7/4, 1957, to 1/20, 1957, that I last saw the deceased
alive on 1/19, 1957, and that death occurred at 10:50 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Leo H. Ley Jr.

M.D.

456 N. Centre St.

1/21/57

PHYSICIAN'S
NAME (Type)

Leo H. Ley Jr. M.D.

Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF
12/23/195722c. NAME OF CEMETERY OR CREMATORIUM
Zion Memorial Cem.22d. LOCATION (City, town, or county)
Cumberland, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE

Byron Knight

ADDRESS

Cumberland, Md.

24a. REC'D BY REGISTRAR
Dec 22, 195724b. REGISTRAR'S SIGNATURE
Tom van Strien, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PERALU V. S.

DEC 10 1957

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12536

12534

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb years		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
						d. STREET ADDRESS 213 Wallace Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY		First ELIZABETH	Middle BROWN	Last	4. DATE OF DEATH December 2	Month December	Day 2	Year 1957	
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 21, 1888	9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 9	Hours 12	Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas H. Cook		14. MOTHER'S MAIDEN NAME Elmira Naylor							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mary E. Brown		213 Wallace Street Cumberland Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Hypertensive Cardi-Vascular Disease							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Cumberland, Maryland		(State)	
21. I certify that I attended the deceased from August , 1957, to December , 1957, that I last saw the deceased alive on December 1, 1957 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Leo Ley, M.D.	
ACTUAL SIGNATURE <i>Leo Ley Jr.</i>								DATE SIGNED 12/4/57	
PHYSICIAN'S NAME (Type) Leo Ley		M.D.						North Centre Street, Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/4/57		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR 4.19.57		24b. REGISTRAR'S SIGNATURE John J. Hafer, Cumberland, Maryland			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12535

12598 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Garrett							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 3 weeks							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, Route 2							
3. NAME OF DECEASED (Type or print) Ralph Andrew		d. STREET ADDRESS							
4. DATE OF DEATH I2		Month	Day						
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-31-1905	9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile engineer		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James H. Brown		14. MOTHER'S MAIDEN NAME Mary Finzel							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. 220-10-0861		17. INFORMANT Mrs. Harley McKenzie, Grantsville, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 586 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Comany & colusion Ruptured Comonoy bilge duct-		INTERVAL BETWEEN ONSET AND DEATH 1 day - 2 wks -					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>Nov. 15, 1957</u> , to <u>Dec. 11, 1957</u> , that I last saw the deceased alive on <u>December 1957</u> , and that death occurred at <u>1:45pm</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>John B. Davis</u> M.D. ADDRESS (Street, city or town, state) <u>Broadway</u> , DATE SIGNED									
PHYSICIAN'S NAME (Type) John B. Davis, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-14-57		22c. NAME OF CEMETERY OR CREMATORIUM Finzel Cemetery		22d. LOCATION (City, town, or county) Finzel, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 12-14-57		24b. REGISTRAR'S SIGNATURE J. R. Durst			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12530

12537

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 11/2/57		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 126 National Highway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Matilda		4. DATE OF DEATH December	Month 8, 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Loar Town, Maryland
13. FATHER'S NAME John McFarland		14. MOTHER'S MAIDEN NAME Elizabeth Loar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Chronic myocarditis Cerebral arteriosclerosis Osteo-arthritis			
INTERVAL BETWEEN ONSET AND DEATH ?			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		(b) DUE TO	?
		(c)	?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/2/57, 19, to 12/8/57, 19, that I last saw the deceased alive on 12/8/57, 19, and that death occurred at 11:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dr. James E. McLean M.D. 49 Greene St. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Dr. James E. McLean DATE SIGNED 12/9/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-57	22c. NAME OF CEMETERY OR CREMATORIAL Eckhart Cemetery
22d. LOCATION (City, town, or county) Eckhart, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR Dec. 11, 1957	24b. REGISTRAR'S SIGNATURE John van Strien, M.D.

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12538 CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY MINERAL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 12 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY		d. STREET ADDRESS CARPENTERS ADDITION		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JOHN		First RUSSELL	Middle	Lost CAMPBELL	4. DATE OF DEATH DECEMBER 18	Month	Day	Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MARCH 10, 1893	8. AGE (In years 64 yrs.)	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roundhouse Foreman		10b. KIND OF BUSINESS OR INDUSTRY W. Md. Rwy.		11. BIRTHPLACE (State or foreign country) VIRGINIA, Shenandoah		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME John CAMPBELL (DECEASED)		14. MOTHER'S MOTHER'S NAME Lola Watson (DECEASED)						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes (If no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) W. W. # 1		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary L. Campbell Carpenter's Add. Ridgeley,		Address W. Va.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4.0 DUE TO <i>Syphilitic Lebernia</i>						INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Ridgeley	(County)	(State)		
21. I certify that I attended the deceased from <i>Dec. 1, 1957</i> to <i>Dec. 18, 1957</i> that I last saw the deceased alive on <i>Dec. 1, 1957</i> , and that death occurred at <i>2:00 A.M.</i> M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 43 Greene St., Cumberland, Md.		DATE SIGNED <i>Dec. 18, 1957</i>		
ACTUAL SIGNATURE <i>Blane M. Schindler</i>		M.D.						
PHYSICIAN'S NAME (Type) BLANE M. SCHINDLER, M.D.				43 GREENE ST., CUMBERLAND, MD.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/20/57		22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR <i>Dec. 20, 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Lowell Steen, M.D.</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12599

CERTIFICATE OF DEATH

12538

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 Blair St.				d. STREET ADDRESS 24 Blair St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES		First T.	Middle CLARK	4. DATE OF DEATH DEC.	Month 24	Day 19	Year 57
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-1903	9. AGE (In years from last birthday) 54 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Potomac Candy Company		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Clark		14. MOTHER'S MAIDEN NAME Mary Cosgrove					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO 217-10-6533		17. INFORMANT Mrs. Rita Clark, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 13, 1957</u> to <u>Dec 24, 1957</u> that I last saw the deceased alive on <u>Dec 24, 1957</u> , and that death occurred at <u>300 Main St.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>W. O. McLane</u> M.D.						ADDRESS (Street, city or town, state) E. Main St., DATE SIGNED <u>Dec 26, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-27-57		22c. NAME OF CEMETERY OR CREMATORIUM St. Michael's Cemetery		22d. LOCATION (City, town, or county) Frostburg, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		ADDRESS J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 12-27-57		24b. REGISTRAR'S SIGNATURE J. R. Durst, Frostburg, Md.	

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12539 CERTIFICATE OF DEATH

12539

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tranit permit. Fill in please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MONMOUTH CUMBERLAND		c. LENGTH OF STAY IN 1b 25 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONACONING							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 44 DOUGLAS AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JANE		First	Middle C.	Last CONNOR	4. DATE OF DEATH DECEMBER 14, 1957	Month	Day	Year			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 28 1889	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) LONACONING, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA					
13. FATHER'S NAME CONNOR, AARON				14. MOTHER'S MAIDEN NAME SPEAR, MARION							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) metastasis to Esophagus DUE TO (c) resulting in stenosis and obstruction										INTERVAL BETWEEN ONSET AND DEATH 20 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 232 Baltimore Ave		(County) Baltimore	(State) Maryland		
21. I certify that I attended the deceased from 11-8 , 19 56 , to 12-14 , 19 57 , that I last saw the deceased alive on 12-14 , 19 57 , and that death occurred at 2:07 P.M. , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) 232 Baltimore Ave	DATE SIGNED
ACTUAL SIGNATURE <i>Carlton Brinsfield</i>	PHYSICIAN'S NAME (Type) DR. CARLTON BRINSFIELD	22d. LOCATION (City, town, or county) LONACONING, MD.								(State) Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/1957		22c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery		22d. LOCATION (City, town, or county) LONACONING, MD.				(State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhern, Lonaconing, MD.		ADDRESS 1919 19th Street, Lonaconing, MD.		24a. REC'D BY REGISTRAR 1919 19th Street, Lonaconing, MD.		24b. REGISTRAR'S SIGNATURE George Eichhern, Lonaconing, MD.					

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DEC. 23 1977

17 April 1811

W.M. D. 1957

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12540

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 132 Fredrick St.				d. STREET ADDRESS 132 Fredrick St.			
e. IS PLS CEN. E ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First William	Middle Albert	Last Coughenour		4. DATE OF DEATH Dec. 9 1957	Month Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20-1891		9. AGE (In years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carnan helper		10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.		11. BIRTHPLACE (State or foreign country) Camp Run, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lason Coughenour				14. MOTHER'S MAIDEN NAME Lennie Deshong			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (For, no, or unknown)				16. SOCIAL SECURITY NO. 17. INFORMANT 05-07-9666 (brother) Harry Coughenour, Elkins, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure				INTERVAL BETWEEN ONSET AND DEATH radius			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic vesicular emphysema				several years.			
DUE TO cause last. (c) Pulmonary fibrosis				?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>				DATE SIGNED			
EXAMINER'S NAME (Type) H.V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Dec. 10-1957			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Maplewood Cemetery		22d. LOCATION (City, town, or county) Elkins, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Kunnen Funeral Home				ADDRESS			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE John Van Strien, M.D.			
VS. A15ME 5M 2/57							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12541

CERTIFICATE OF DEATH

Reg. Dist. No. ..

12541

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 722 Oldtown Road	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mildred	Middle Louise	Last Davis
4. DATE OF DEATH	Month December	Day 28,	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5/4/1905
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (in years last birthday) 52 yrs	
10a. KIND OF BUSINESS OR INDUSTRY Own Home		10b. BIRTHPLACE (State or Foreign country) Westernport, Maryland	
11. CITIZEN OF WHAT COUNTRY? U. S. A.		12. FATHER'S NAME Thomas Leake	
13. MOTHER'S MAIDEN NAME Cordelia Crawford		14. SOCIAL SECURITY NO.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Cerebral Hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Hypostasis Chronic Myocarditis Cerebral Arteriosclerosis		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 49 Greene St.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/23/57 , 19, to 12/28/57 , 19, that I last saw the deceased alive on 8/23/57 , 19, and that death occurred at 12:45 PM , from the causes and on the date stated above. ACTUAL SIGNATURE James E. McLean	ADDRESS (Street, city or town, state) 49 Greene St.	DATE SIGNED 12/30/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/31/57	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	22d. LOCATION (City, town, or county), (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lewis Stein Jr.	ADDRESS Cumberland, Md.	REG'D BY REGISTRAR Dec. 31, 1957	24b. REGISTRAR'S SIGNATURE John van Strien, M.D.

TO HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Please be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

12542

CERTIFICATE OF DEATH

Reg. Dist. No.

42542

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burberland		c. LENGTH OF STAY IN 1b 1 day 2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 323 Howard St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spaced Heart				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William		First W.	Middle E.	Last Davis	4. DATE OF DEATH 12 - 10 - 57	Month 12	Day 10	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-3-25	9. AGE (In years last birthday) 32 yrs.	10. IF UNDER 1 YEAR Months 32	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Brinley Davis		14. MOTHER'S MAIDEN NAME Eleda Gordon						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO W.W. 2 722-12-3324		17. INFORMANT Patients chart		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema DUE TO (c) Pericarditis B-enzymonin								
INTERVAL BETWEEN ONSET AND DEATH 24 hours								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 441 Centre St	(County) Cumberland	(State) Md.	
21. I certify that I attended the deceased from Nov. 22, 1957 to Dec. 10, 1957 , that I last saw the deceased alive on Dec. 10, 1957 , and that death occurred at 8 P.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) 441 Centre St, Cumberland, Md.								
DATE SIGNED 12-12-57								
ACTUAL SIGNATURE William R. James								
PHYSICIAN'S NAME (Type) William R. James								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-13-57		22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Md.		
(State)								
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Dec. 13, 1957		24b. REGISTRAR'S SIGNATURE Jon van Stuiven M.D.		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12543

12543

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12/22/51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) Leona Wolford		First Leona	Middle Wolford
4. DATE OF DEATH Death		Last Death	Month December Day 26, 1957
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10/31/1880		9. AGE (In years lost birthday) 77 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alex Kidwell		14. MOTHER'S MAIDEN NAME Ellen Moreland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599 Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4... DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 24 hours			
Cerebral Hemorrhage.			
Cerebral arteriosclerosis ?			
Chronic myocarditis ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Rt. Hemiplegia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/22/51 , 19, to 12/26/57 , 19, that I last saw the deceased alive on 12/26/57 , 19, and that death occurred at 3:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James E. McLean</i>		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/27/57	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/1957	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Union Cemetery		22d. LOCATION (City, town, or county) Hampshire Co. Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR 12/28/1957		24b. REGISTRAR'S SIGNATURE Tom Van Allen, Md.	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12600 CERTIFICATE OF DEATH

12544

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 18 Beall's Lane		d. STREET ADDRESS 18 Beall's Lane	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna		First M.	Middle Dennison
4. DATE OF DEATH 12		Month 12	Day 22
		Year 1957	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 4-16-1867		9. AGE (In years lost birthday) 90 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Frostburg		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Justus Rase		14. MOTHER'S MAIDEN NAME Elizabeth Deal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clayton Dennison, Frostburg, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 440.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Coronary Thrombosis Arterio Sclerosis Seneal years	
		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19, to <u>Dec 22</u> , 1927, that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>57</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>WOMC Lane</u> PHYSICIAN'S NAME (Type) <u>WOMC Lane MD</u>		ADDRESS (Street, city or town, state) <u>Frostburg</u> DATE SIGNED <u>Dec 23 1957</u>	
22d. BURIAL, CREMATION, REMOVAL (Specify) Burial		22e. DATE THEREOF 12/24/57	
22f. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park		22g. LOCATION (City, town, or county) Frostburg (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home 23 E. Main, Frostburg		24a. REC'D BY REGISTRAR DATE 12/24/57	
		24b. REGISTRAR'S SIGNATURE <u>John J. Slattery N.D.P.</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12601

CERTIFICATE OF DEATH

Reg. Dist. No. 4

12545

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shaft, Rural # 1 Frostburg, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EMMA	Middle DUNCAN	4. DATE OF DEATH 12/28/1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6. 1890
9. AGE (In years lost birthday) 67		10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Hours 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Meagher		14. MOTHER'S MAIDEN NAME Lucinda Bowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Name, no. or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. William Landerfeld, (Daughter)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Mononucleosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 27, 1957 to Dec. 28, 1957 , that I last saw the deceased alive on Dec. 28, 1957 , and that death occurred at 4 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) GEORGE EICHORN, LONACONING, MD. DATE SIGNED Dec. 28, 1957			
ACTUAL SIGNATURE George R. Miles, M.D.		NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/1957	
22c. NAME OF CEMETERY OR CREMATORIAL Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN, LONACONING, MD.		24a. REC'D BY REGISTRAR DATE 12-31-57	
		24b. REGISTRAR'S SIGNATURE John Sherry, N.D.	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Within corporate limits

12544

CERTIFICATE OF DEATH

12546

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 811 EDGEWOOD DRIVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LILLIAN	Middle E.	Last EICHNER
4. DATE OF DEATH	Month DECEMBER	Day 11	Year 19 57
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 26, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM JUDY		14. MOTHER'S MAIDEN NAME MARGARET KEADY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL		Address - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma</i> 100% DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Dorcinoma of left breast</i> Over 6 years. (c) DUE TO <i>Operated - breast removed in 1951.</i>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-31-1957 to 12-11-1957 , that I last saw the deceased alive on 12-11-1957 , and that death occurred at 10:25PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>M. F. Williams</i>		ADDRESS (Street, city or town, state) CUMBERLAND, MD. DATE SIGNED 12-11-1957	
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22a. BURIAL, CREMATION, REMOVAL (Specify) 12/11/57	
22b. DATE THEREOF 12/11/57		22c. NAME OF CEMETERY OR CREMATORIAL Memorial Cem.	
22d. LOCATION (City, town, or county) Cumberland (State) MD.		24a. REC'D BY REGISTRAR DATE Dec. 13, 1954	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. (not M.D.)		24b. REGISTRAR'S SIGNATURE John van Stein M.D.	

Y. A. MUNIZ

18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12545 CERTIFICATE OF DEATH

Reg. Dist. No.

12547

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 100 SOUTH STREET		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) THELMA		First R.	Middle EMERY	Lost	4. DATE OF DEATH DECEMBER 20	Month 19	Day 57	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCT. 14, 1900	9. AGE (In years lost birthday) 57	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? Cumberland USA		
13. FATHER'S NAME ASA. TRONS. (DECEASED)		14. MOTHER'S MAIDEN NAME MARY BUCY (DECEASED)						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. [If yes, give war or date of service]		17. INFORMANT		Address		
PATIENTS CHART								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SACROMATOSIS INTERVAL BETWEEN ONSET AND DEATH 2 MON.								
1/1 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) FIBRO-SARCOMA UTERI 1 YR. DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland		(County) Cumberland	(State) MD
21. I certify that I attended the deceased from 12-11-1957 to 12-20-1957 , that I last saw the deceased alive on 12-19-57 , and that death occurred at 3:50A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>cc Zimmerman</i>		ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 12-20-57						
PHYSICIAN'S NAME (Type) C. C. ZIMMERMAN, M.D.		122 S. CENTRE ST., CUMBERLAND, MD.						
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-22-57	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.			(State) MD
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR 1957-12-21, 1957		24b. REGISTRAR'S SIGNATURE Barry Street, M.D.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LEWIS V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12548

12546

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE		d. STREET ADDRESS 21 RYE STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 21 RYE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ZETTA		First ZETTA	Middle LUCILLE	4. DATE OF DEATH DECEMBER 9 1957.	Month DECEMBER	Day 9	Year 1957.
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 10, 1891	9. AGE (In years last birthday) 66	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) BANNER RIDGE, PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM MC FADDEN		14. MOTHER'S MAIDEN NAME ELIZABETH BISHOP					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X		DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost. 442X		DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 4:50A.M.		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from July 1957 to Dec. 8 1957 that I last saw the deceased alive on Dec. 8 1957 and that death occurred at 4:50A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 153 Va Ave, Cumberland, Md.		DATE SIGNED 12/9/57			
ACTUAL SIGNATURE R. Wayne George		PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELRIGHT					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.		ADDRESS 1010 10th St. S.E., Washington, D.C.		24a. REC'D BY REGISTRAR Dec. 10, 1957		24b. REGISTRAR'S SIGNATURE John van Strien, M.D.	

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BUNN V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12549

12547

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN lb 7yr, 4mo, 16da			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat, Furnace St.				d. STREET ADDRESS 408 Columbia			
3. NAME OF DECEASED (Type or print)		First Bernadette	Middle Fahey	4. DATE OF DEATH 12	Month Month	Day 26	Year 1957
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 19 1880	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10b. KIND OF BUSINESS OR INDUSTRY Own House		11. BIRTHPLACE (State or foreign country) Cumberland, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard Fahey				14. MOTHER'S MAIDEN NAME Mary J Shay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Records Sylvan Retreat, Cumberland, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 472.2 DUE TO Hypostatic congestion Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Chronic myocarditis (c) DUE TO Cerebral arteriosclerosis Senile psychosis							
INTERVAL BETWEEN ONSET AND DEATH 48 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe psychosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Md	(State) Md
21. I certify that I attended the deceased from <u>Dec. 24, 1957</u> to <u>Dec. 26, 1957</u> , that I last saw the deceased alive on <u>Dec. 24, 1957</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. McLean</u> M.D.				ADDRESS (Street, city or town, state) 49 Green St.			
PHYSICIAN'S NAME (Type) Dr. J. E. McLean				DATE SIGNED 12/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 28/57		22c. NAME OF CEMETERY OR CREMATORIUM St. Patricks Cemetery		22d. LOCATION (City, town, or county) Cumberland	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.			
				24a. REC'D BY REGISTRAR DEC 28 1957		24b. REGISTRAR'S SIGNATURE J. W. Kight, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12548

CERTIFICATE OF DEATH

12550

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 715 Arundel St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ethel		First Ethel	Middle L.	4. DATE OF DEATH Fairall	Month Dec.	Day 27	Year 19 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-1889	9. AGE (In years lost birthday) 68 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) West Virginia, Keyser		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lemuel Nixon		14. MOTHER'S MAIDEN NAME Amanda Nixon		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Patient's Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H20.1 DUE TO Coronary Sclerosis INTERVAL BETWEEN ONSET AND DEATH 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) IMMEDIATE CAUSE (b) DUE TO Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 27, 1957 to Dec. 27, 1957 that I last saw the deceased alive on Dec. 27, 1957 , and that death occurred at M. from the causes and on the date stated above. ACTUAL SIGNATURE Clay E. Durrett M.D. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 12/28/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30, 1957		22c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarfelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Dec. 28, 1957		24b. REGISTRAR'S SIGNATURE Joe van Strien, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12602 CERTIFICATE OF DEATH

12551

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN lb 72 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 Walnut		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
3. NAME OF DECEASED (Type or print) Edward		First Walters	Middle Fazenbaker
4. DATE OF DEATH Dec. 11		Month 19	Day 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8. DATE OF BIRTH June 13, 1885		9. AGE (In years last birthday) 72 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weilder		10b. KIND OF BUSINESS OR INDUSTRY Natural gas Ind.	
11. BIRTHPLACE (State or foreign country) Westernport, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Rebecca Fazenbaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. If yes, give war or dates of service)	
17. INFORMANT Mrs. May Fazenbaker-Westernport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 6 months	
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last.		DUE TO (c)	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1957, to 12/14/57, that I last saw the deceased alive on 12/14/57, and that death occurred at 6 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE P. E. Berry PHYSICIAN'S NAME (Type) P. E. Berry			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/57	
22c. NAME OF CEMETERY OR CREMATORIUM Philos		22d. LOCATION (City, town, or county) Westernport (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE El Boal		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR DATE 12-14-57		24b. REGISTRAR'S SIGNATURE Jean C. Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1881

12552

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 1 yr. 1 mo. 8 da.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat, Furnace St.			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mc Coole, Md.		
3. NAME OF DECEASED (Type or print) Wesley			d. STREET ADDRESS		
First Middle Sylvester			4. DATE OF DEATH Fike 12 31 1957		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1883	9. AGE (In years last birthday) 74	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner			10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (State or foreign country) W.Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel Fike			14. MOTHER'S MAIDEN NAME Not known		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 00	17. INFORMANT Mrs. Jess Cook	Address McCoole, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH ? ? ?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Severe psychosis		
20c. TIME OF INJURY Hour p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) McCoole	(County) Md.
21. I certify that I attended the deceased from <u>Nov. 23, 1956</u> to <u>Dec. 31, 1957</u> , that I last saw the deceased alive on <u>Dec. 30, 1957</u> , and that death occurred at <u>1:25 a. M.</u> from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
ACTUAL SIGNATURE Dr. J. E. Mc Lean			ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/31/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/3/58	22c. NAME OF CEMETERY OR CREMATORIAL Nethken Hill Cem.	22d. LOCATION (City, town, or county) Elkgarden	(State) W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE El. Baval			24a. REC'D BY REGISTRAR DATE 1/3 1958	24b. REGISTRAR'S SIGNATURE W. H. Hurdish	
ADDRESS Westernport, Md.					

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A form

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12553

Within corporate limits

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 this should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and to any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 48 yrs				
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1011 Virginia Ave.		e. STREET ADDRESS 1011 Virginia Ave.				
3. NAME OF DECEASED (Type or print) Caroline Elizabeth Foard		First	Middle			
4. DATE OF DEATH Dec. 5, 1957		Month	Day			
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH April 20, 1897		9. AGE (In years last birthday) 60	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) Inspector Retired		10b. KIND OF BUSINESS OR INDUSTRY Textile Mill	11. BIRTHPLACE (State or foreign country) Doegulley W. Va.			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Peter L. Ziler				
14. MOTHER'S MAIDEN NAME Vertiebell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. PI3-22-3690		17. INFORMANT James S. Foard 1011 Virginia Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic and coronary heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 years				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) _____ DUE TO (c) Diabetes mellitus mild		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) unknown				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 62 Greene St.	20f. (City or town) MD	(County) 62	(State) Green St.
21. I certify that I attended the deceased from 2-15 , 19 57 to 12-5 , 19 57 , that I last saw the deceased alive on 12-5 , 19 57 , and that death occurred at 1:15 p.m. from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) 62 Greene St.						
DATE SIGNED 12-6-57						
ACTUAL SIGNATURE Ralph W. Ballin						
PHYSICIAN'S NAME (Type) Ralph W. Ballin						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-57	22c. NAME OF CEMETERY OR CREMATORIUM St Mary Cem.	22d. LOCATION (City, town, or county) Cumberland, Md.	(State) Green St.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli			ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR Dec. 7, 1957	24b. REGISTRAR'S SIGNATURE James F. Scarpelli	

SAVANNAH V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12554

12551 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 57 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 118 GRAND AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNA		First ANNA	Middle Aliden	Last GANK	4. DATE OF DEATH DECEMBER 1 1957	Month DECEMBER	Day 1	Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 20, 1872	9. AGE (in years from birthday) 85xx yrs	10. IF UNDER 1 YEAR Months 85xx yrs	11. IF UNDER 24 HRS. Days 85xx hrs	12. IF UNDER 24 HRS. Hours 85xx min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Our Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Francis W. PURINTON		14. MOTHER'S MAIDEN NAME FLORENCE xxxx Howell		Address MEMORIAL HOSPITAL - CUMBERLAND, MD.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Urinary chronic myocarditis Parotitis leg tx		INTERVAL BETWEEN ONSET AND DEATH 6 weeks 3 yrs 2 wks					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct. 4, 1957 to Dec. 1, 1957 that I last saw the deceased alive on Nov. 30, 1957 , and that death occurred at 4:17 AM , from the causes and on the date stated above.							ADDRESS (Street, city or town, state) Cumberland, Md.		
ACTUAL SIGNATURE <i>Clay E. Durrett</i>							DATE SIGNED 12/3/57		
PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		286 Virginia Avenue, Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR John J. Hafer, Cumberland, Maryland		24b. REGISTRAR'S SIGNATURE John J. Hafer, Cumberland, Maryland			

LEADER V. 3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12603

CERTIFICATE OF DEATH

Reg. Dist. No. 6

12555

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westerport		c. LENGTH OF STAY IN 1b 7 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport 47		d. STREET ADDRESS 73 Main		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 73 Main				d. STREET ADDRESS 73 Main		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John		First Pringle	Middle Garrard	4. DATE OF DEATH Dec.	Month Dec.	Day 31	Year 1957	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1879	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Issac Garrard				14. MOTHER'S MAIDEN NAME Estella Pringle				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edw. Murphy		Address Westernport, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <i>Chronic Myocarditis and Myocardial</i> PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Degeneration Not Specified as Rheumatic</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 Year</i> DUE TO 4 L Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) None								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Piedmont, W. Va.	(County)	(State)
21. I certify that I attended the deceased from <i>Oct. 10, 1957</i> to <i>Dec. 31, 1957</i> , that I last saw the deceased alive on <i>Dec. 30, 1957</i> , and that death occurred at <i>8:00 A.M.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Paul B. Wilson</i>				ADDRESS (Street, city or town, state) Piedmont, W. Va.		DATE SIGNED <i>Dec. 31, 1957</i>		
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/58	22c. NAME OF CEMETERY OR CREMATORIAL Queens Point Cem.			22d. LOCATION (City, town, or county) Keyser,	(State) W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. B. Burd</i>		ADDRESS Westernport, Md.			24a. RECD BY REGISTRAR DATE 12/31-57	24b. REGISTRAR'S SIGNATURE <i>Tom C. Kelly</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12556

12604

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		d. STREET ADDRESS Gunter Hotel, W. Main Street,	
3. NAME OF DECEASED (Type or print) Herbert		First H.	Middle Lou
4. DATE OF DEATH Dec. 15th, 1881		Month December	Day 8th, 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15th, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Station Agent		10b. KIND OF BUSINESS OR INDUSTRY C&PRRCo.	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William Griffith		14. MOTHER'S MAIDEN NAME Annie Bomar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 214-05-7836	17. INFORMANT Mrs. Sophia Griffith, 80 W. Main St., F'bg. Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, right, with apparent</u> DUE TO <u>massive cerebral infarct.</u>		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 27. <u>Chronic Alcoholism</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/6/57</u> , 19 <u>19</u> , to <u>12/8/57</u> , 19 <u>19</u> , that I last saw the deceased alive on <u>12/8/57</u> , 19 <u>19</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Martin M. Rothstein M.D.</i>		ADDRESS (Street, city or town, state) 48 Broadway DATE SIGNED 12/9/57	
PHYSICIAN'S NAME (Type) Martin M. Rothstein M.D.		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-10-57	22c. NAME OF CEMETERY OR CREMATORIUM Eckhart Cemetery	22d. LOCATION (City, town, or county) Eckhart, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 12-10-57 24b. REGISTRAR'S SIGNATURE <i>Mary N. [Signature]</i>	

RECEIVED
BUREAU V. S.

DEC

Within corporate limits

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with
the information given on the death certificate and then attached to the burial/transit permit. Then attach the burial/transit permit
prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12552

CERTIFICATE OF DEATH

Reg. Dist. No. 4

12557

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 HR. 40 MIN.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12. CUMBERLAND	
3. NAME OF DECEASED (Type or print) First JENNIE Middle DIANE		d. STREET ADDRESS 1 1608 BEDFORD STREET	
4. DATE OF DEATH Harshberger		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> DEC. 18, 1957	
9. AGE (in years (last birthday) yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME FRED H. HARSHBERGER		14. MOTHER'S MAIDEN NAME PHYLLIS M. MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT None MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 770.0 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-19-1957 to 12-19-1957 that I last saw the deceased alive on 12-19-1957, and that death occurred at 2:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED M.D. 126 Monroe St. Cumberland, MD 12-19-57	
ACTUAL SIGNATURE DR. H.W. ELIASON			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF DEC. 30, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR 12-30-1957	
		24b. REGISTRAR'S SIGNATURE John J. Hafer, Cumberland, Maryland	

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The copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12558

12553

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Allegany Cumberland	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	203 Wallace St.	67 yrs.	STREET ADDRESS (If rural give location) 203 Wallace St.
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		Dec 14 1957	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	White	widowed	June 3, 1878
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country)
79	Sheet Metal	Own Business	Maysville, W. Va.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Joseph Hartman		Caroline Rossworm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.		
no	214-05-5709		
17. INFORMANT & ADDRESS			
Mrs. Thomas Mc Mahon, Cumberland			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
430.1 IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO			
(C) <i>Arteriosclerosis</i>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/11/53</i> , 19 <i>53</i> , to <i>12/14</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>12/14</i> , 19 <i>53</i> , and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Geo. W. Ley Jr.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL M.D. <i>456 N. Centre St. Cumberland, Md. 1954</i>
Burial		12-17-57	LOCATION (City, town, or county) (State) Cumberland, Md.
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James F. Scarelli, Cumberland
Dec. 17, 1957		<i>Towson/Strain, M.D.</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12605 CERTIFICATE OF DEATH

12559

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 5 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 62 Spring Street		d. STREET ADDRESS 62 Spring Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) HELEN		First HELEN		Middle 		Last HARVEY		4. DATE OF DEATH 12		Month 12		Day 31		Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-5-1878		9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 		11. IF UNDER 24 HRS Days 		12. IF UNDER 24 HRS Hours 		13. CITIZEN OF WHAT COUNTRY U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Midlothian		12. CITIZEN OF WHAT COUNTRY U.S.A.											
13. FATHER'S NAME Charles Conrad		14. MOTHER'S MAIDEN NAME Margaret Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. James L. Davis,		Address 62 Spring St., Frostburg, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 hrs													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		arterio sclerosis															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 		(County) 		(State) 							
21. I certify that I attended the deceased from Dec 17 , 1957, to Dec 21 , 1957, that I last saw the deceased alive on Dec 20 , 1957, and that death occurred at 2:45 PM , from the causes and on the date stated above.		ACTUAL SIGNATURE W.M. Lane		M.D. W.M. Lane MD		ADDRESS (Street, city or town, state) Frostburg, Md.		DATE SIGNED Jan 2 1958									
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1-3-1958		22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park		22d. LOCATION (City, town, or country) Frostburg		(State) Md.									
23. FUNERAL DIRECTOR'S SIGNATURE P.H. Hafer		23. ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.		24. SIGNED BY REGISTRAR JAN 6 1958		24b. REGISTRAR'S SIGNATURE Nancy Lucy											

RECEIVED

JUN 9 1969

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. ATTS.
EM 2.57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

12606

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12560

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE W. Va. b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wiley Ford	
f. STREET ADDRESS		f. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Edward Heavner		4. DATE OF DEATH Month Dec. Day 13 Year 1957	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 23-1877	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Moorefield, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jesse Heavner		14. MOTHER'S MAIDEN NAME Mary Pope	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (son) Jesse J. Heavner, Wiley Ford, W. Va.	
17. INFORMANT Coronary occlusion		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Summer	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Generalized arteriosclerosis			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Denning M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Denning M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Dec. 14-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) Moorefield, W. Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		24a. REC'D BY REGISTRAR DATE Dec. 16, 1957	
		24b. REGISTRAR'S SIGNATURE Son van Steen M.D.	

070

AP-201

Within corporate MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12561

12554

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FISHER 85X-1	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last HIGH		4. DATE OF DEATH Month DECEMBER Day 12 Year 1957	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH DECEMBER 12, 1957	
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN B. HIGH		14. MOTHER'S MAIDEN NAME MAXINE DELAWDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO M. B. HIGH Preivable Prematurity INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at 4:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Leland L. Ransom M.D. 63 Green St., Cumberland, Md. 12 Dec 1957	
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) DR. L. RANSOM	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF Dec 12, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Memorial Hospital		22d. LOCATION (City, town, or county) Cumberland	
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital		24a. REC'D BY REGISTRAR DATE: Dec. 13, 1957	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE Fox van Steen, M.D.	

BUZBY W. S.
REC'D 12/25/64

CERTIFICATE OF DEATH

12607

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 3 hrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 217 Maple St.				
3. NAME OF DECEASED (Type or print) MARY		First ELLEN	Middle HOBAN			
4. DATE OF DEATH DEC.	Month 25	Day 19	Year 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-1890	9. AGE (In years last birthday) 67 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen helper		10b. KIND OF BUSINESS OR INDUSTRY Finzel's Restaurant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Price Hayes		14. MOTHER'S MAIDEN NAME Lydia Winebrenner		Address Orville Hoban, Frostburg, Md.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 220-16-6491		17. INFORMANT		18. INTERVAL BETWEEN ONSET AND DEATH 2 days
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Coronary occlusion Hypertensive Cardiovascular disease few years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Doy, Year Hour o. m p. m 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 1, 1957</u> to <u>Dec 5, 1957</u> that I last saw the deceased alive on <u>Dec 5, 1957</u> , and that death occurred at <u>1201 M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>John B. Davis</u> M. D. ADDRESS (Street, city or town, state) John B. Davis, M. D. Broadway, Frostburg, Md.				DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-57		22c. NAME OF CEMETERY OR CREMATORIUM St. Michael's Cemetery		22d. LOCATION (City, town, or county) Frostburg, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 12-28-57		24b. REGISTRAR'S SIGNATURE Mrs. Mary H. Rose

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 this certificate should be detached for use as the burial-transit permit. Then, please remove carbon papers. Page 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3. A. 3

Within Corporate Limits

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File Pages 1 and 2 with the Board of Health, or designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

12563

1. PLACE OF DEATH a. COUNTY Allegany	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE W. Va. b. COUNTY Mineral				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wiley Ford				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital	d. STREET ADDRESS	e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Galen	First Galen	Middle G. Howdyshell	Last Howdyshell	4. DATE OF DEATH Month Dec. Day 18 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 16-1956	9. AGE (In years, to nearest birthday) 1 yrs	10. IF UNDER 14 YEARS OF AGE Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Galen Howdyshell		14. MOTHER'S MAIDEN NAME Consuelo Miller		Address (father) Galen Howdyshell, Wiley Ford, W. Va.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or date of service) none	17. INFORMANT (father) Galen Howdyshell	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Incubitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Wiley Ford	(County) Mineral	(State) W. Va.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>H. F. Dering M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED Dec. 18-1957		
EXAMINER'S NAME (Type) V. Dering M.D.	22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery			22d. LOCATION (City, town, or county) Fort Ashby, West Virginia		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 21, 1957	22e. REC'D BY REGISTRAR Joe van Strien, M.D.			(State) W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		24b. REGISTRAR'S SIGNATURE Joe van Strien, M.D.				

THEATER

DEC 25 1977

THEATER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12556

CERTIFICATE OF DEATH

12564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b 9/22/54		d. STREET ADDRESS 115 Hanover St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Emma	Middle F.	Last Jones
4. DATE OF DEATH	Month December	Day 16,	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10/22/1878
9. AGE (In years from birthdate) 79		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Conrad Frey		14. MOTHER'S MAIDEN NAME Margaret Seifert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT P.O. Box 599		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1900 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Chronic myocarditis (b) DUE TO Generalized arteriosclerosis (c) Chronic nephritis	
		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/22/54 , 19, to 12/16/57 , 19, that I last saw the deceased alive on 12/15/57 , 19, and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/16/57			
ACTUAL SIGNATURE <i>Dr. James E. McLean</i>		PHYSICIAN'S NAME (Type) Dr. James E. McLean	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-57	
22c. NAME OF CEMETERY OR CREMATORIUM St Peter & Paul Cem		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24a. REC'D BY REGISTRAR DATE Dec. 19, 1957	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE James F. Scarpelli	

BUNN 6 1

DEC 3 1977



12557

CERTIFICATE OF DEATH

Reg. Dist. No.

12565

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			
c. LENGTH OF STAY IN 16 40 DAYS				d. STREET ADDRESS 153 W. MAIN ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle MARTIN	Last JOYCE	4. DATE OF DEATH DECEMBER 20	Month Day Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 9, 1901	9. AGE (In years at birthday) 56	10. IF UNDER 1 YEAR Months 56	11. IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CUMB. CEMENT & SUPPLY CO.		11. BIRTHPLACE (State or foreign country) CARLOS, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA	
13. FATHER'S NAME JOYCE, PATRICK				14. MOTHER'S MAIDEN NAME DONAHUE, ANNA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 214-01-3767			
17. INFORMANT Mrs. Naomi Joyce, Frostburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>Typhemia, anemia, cachexia</i> <i>chronic massive bilateral lung infection 6 months</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Year	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from May , 1957, to December , 1957, that I last saw the deceased alive on Dec. 20 , 1957, and that death occurred at 8:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Thomas F. Lewis</i> M.D.							
DATE SIGNED							
PHYSICIAN'S NAME (Type) DR. THOMAS LEWIS							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Dec 23-57		22c. NAME OF CEMETERY OR CREMATORIAL St. Michaels		22d. LOCATION (City, town, or county) Frostburg - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Deen</i>							
VS. A15 (4) 15M 9/55				ADDRESS Frostburg, Md.	24a. REC'D BY REGISTRAR DATE Dec 21, 1957	24b. REGISTRAR'S SIGNATURE Jon van Stien, M.D.	

BURLIN V. A.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

12559 CERTIFICATE OF DEATH

Reg. Dist. No.

12567

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with
 the record.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut. on. Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Old CUMBERLAND		d. STREET ADDRESS 109 E. FIRST STREET					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EDITH		First IRENE	Middle KIRTLEY	Last KIRTLEY	4. DATE OF DEATH DECEMBER 12 1957	Month DECEMBER	Day 12	Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH SEPT. 17, 1891	9. AGE (In years from birthday) 66 yrs	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. Months 0	14. Days 0	15. Minutes 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA					
13. FATHER'S NAME ANSEL, WILLIAM		14. MOTHER'S MAIDEN NAME BRANT, Hattie									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4222 <i>Chronic Myocarditis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Rheumatoid Arthritis</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6-mo					
						<i>8 yrs</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 236 Virginia Ave.		(County) Cumberland		(State) Md.	
21. I certify that I attended the deceased from June 1952 to Dec. 12, 1957 , that I last saw the deceased alive on Dec. 11, 1957 , and that death occurred at 9:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 Virginia Ave., Cumberland, Md.										DATE SIGNED 12/12/57	
ACTUAL SIGNATURE <i>Clay E. Durrett</i>											
PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-57		22c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial		22d. LOCATION (City, town, or county) Cumberland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR Dec 16, 1957		24b. REGISTRAR'S SIGNATURE John van Steen M.D.					

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12560

CERTIFICATE OF DEATH

12568

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 705 Princeton Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ralph Frederick Knippenberg		First	Middle	Last	4. DATE OF DEATH December 20 1957	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1900	9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lndry Worker		10b. KIND OF BUSINESS OR INDUSTRY Alleg. Co. Infirmary		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Knippenberg				14. MOTHER'S MAIDEN NAME Beatrice Irons		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI 214-05-7277		17. INFORMANT Pt.'s Chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 d.o.i		acute cardiac dilatation 3 wk.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)		Myocardial infarction, recent 3 wk.							
DUE TO (c)		coronary heart disease 4 wk.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Month, Day, Year Hour o. m. NOV 20 1957 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) None		(County) None (State) None	
21. I certify that I attended the deceased from NOV. 20, 1957 to Dec. 20, 1957 , that I last saw the deceased alive on December 20, 1957 , and that death occurred at 7:05 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 140 Bedford St., Cumberland, Maryland							DATE SIGNED 12/20/57
ACTUAL SIGNATURE James J. Hafer		M.D.							
PHYSICIAN'S NAME (Type) Dr. J. P. Hallinan		Cumberland, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Sunset Mem. Park		22d. LOCATION (City, town, or county) Cumberland, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS None							
		24a. REC'D BY REGISTRAR Dec. 20, 1957							
		24b. REGISTRAR'S SIGNATURE John J. Hafer, Cumberland, Maryland							

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DEC 23 1977

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12569

12561 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 112 S. Johnson St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charlotte	Middle Lottie	Last Koelker	4. DATE OF DEATH December 31	Month 1957	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8/19/1883	9. AGE (In years 1st birthday) 74	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired machine operator		10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.		11. BIRTHPLACE (State or foreign country) New Creek, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Sellars		14. MOTHER'S MAIDEN NAME Margaret Mac Donald		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT pts. chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 44dx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) NEPHROSCLEROSIS 1 year. DUE TO (c) ARTERIOSCLEROTIC CARDIOMYOPATHY DISEASE 10 years. RENAL							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? 101 hypertension hyd. Thora due to Heart Failure YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12 p. m. 31		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/22/57 to 12/31/57 that I last saw the deceased alive on 12/20/57 , and that death occurred at 1:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 Greene St., Cumberland, Md. DATE SIGNED 12/31/57							
ACTUAL SIGNATURE S. G. Weisman, M.D.							
PHYSICIAN'S NAME (Type) S. G. Weisman, M.D.		22d. LOCATION (City, town, or county) Westernport, Md. (State)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 3, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Philos Cemetery		22d. LOCATION (City, town, or county) Westernport, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				ADDRESS 59 Greene St., Cumberland, Md.		24a. REC'D BY REGISTRAR 12/31/57	
						24b. REGISTRAR'S SIGNATURE W. H. Drury	

NUMBER A. S

100-1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12617 CERTIFICATE OF DEATH

12570

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings		c. LENGTH OF STAY IN 1b Along Md. Rt. # 28		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Along Md. Rt. # 28		d. STREET ADDRESS Along Md. Rt. # 28								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Norah		First Lee		Middle Lease		4. DATE OF DEATH December 23, 1957		Month Day Year					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1867		9. AGE (in years last birthday) 90 yrs		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Days 0		12. IF UNDER 24 HRS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Springfield, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Leonard Huff		14. MOTHER'S MAIDEN NAME Elizabeth Davis											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. John F. Lease Rawlings, Maryland		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Hemiplegia left		INTERVAL BETWEEN ONSET AND DEATH 12-10-57							
DUE TO (b)		arteriosclerosis, marked											
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pipitis chronic, myositis chronic.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 12-20-57											
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy 19	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Keyser, W. Va.	(County) W. Va.	(State) W. Va.					
21. I certify that I attended the deceased from 12-2 , 19 56 , to 12-20 , 19 57 , that I last saw the deceased alive on 12-20 , 19 57 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.													
ADDRESS (Street, city or town, state) Keyser, W. Va.													
DATE SIGNED 12-26-57													
ACTUAL SIGNATURE T. C. Giffin M. D.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/57		22c. NAME OF CEMETERY OR CREMATORIUM Biertown Cemetery		22d. LOCATION (City, town, or county) Biertown, Maryland		(State) W. Va.					
23 FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR REC. 26, 1957		24b. REGISTRAR'S SIGNATURE Tow van Steen, M. D.							

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the death certificate.

A15 (4)
9/55

BULLARD V. S

DEC

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12571

Within corporate limits DR. WHITWORTH

12562 CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 17 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY MINERAL									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3 NAME OF DECEASED (Type or print) ELA		First M.		Middle LEATHERMAN		Last DECEMBER		Month 18		Day 19		Year 57					
4. DATE OF DEATH		5. COLOR OR RACE WHITE		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. DATE OF BIRTH MAY 15, 1915		8. AGE (in years last birthday) 42 yrs.		9. IF UNDER 1 YEAR Months 0		10. IF UNDER 24 HRS Days 0		11. IF UNDER 24 HRS Hours 0		12. IF UNDER 24 HRS Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME GUY SNYDER		14. MOTHER'S MAIDEN NAME EMMA ROBERTS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Unrein		DUE TO Generalized Carcinomatosis		DUE TO Adeno Carcinoma Cervix		INTERVAL BETWEEN ONSET AND DEATH									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from April , 1957, to Dec , 1957, that I last saw the deceased alive on 17 Dec , 1957, and that death occurred at 12:50 M, from the causes and on the date stated above. ACTUAL SIGNATURE Allen M. Whitworth		ADDRESS (Street, city or town, state) Memorial Hospital - Cumberland, Md. 19170															
PHYSICIAN'S NAME (Type) DR. WHITWORTH		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 21, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Headsville Cemetery		22d. LOCATION (City, town, or county) Headsville, West Virginia		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE Rogers Funeral Home		ADDRESS Allen M. Whitworth Keyser, W. Va.		24a. REC'D BY REGISTRAR DATE 19/1957		24b. REGISTRAR'S SIGNATURE John W. Strain, M.D.											

1900

DEC 22 1977

1960-1961

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12572

Within corporate limits

12563 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		e. STREET ADDRESS <i>1035 Myrtle Street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Special Heart Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Wm. F. Light</i>	First <i>Howard</i>	Middle <i></i>	Last <i>Light</i>
4. DATE OF DEATH <i>12/11/1957</i>	Month <i>12</i>	Day <i>11</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/16/1870</i>
9. AGE (In years lost birthday) <i>87 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Contractor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William F. Light</i>		14. MOTHER'S MAIDEN NAME <i>Person Light</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>214 05 7758</i>	
17. INFORMANT <i>Rt. Churt</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>157x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Benign prostatic hyperplasia</i> (b) DUE TO <i>Carcinoma of prostate</i> (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma of prostate; anorexia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/8</i> to <i>Dec 11, 1957</i> that I last saw the deceased alive on <i>Dec 6, 1957</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Allegany</i> M.D. <i>507 Greene St</i> DATE SIGNED <i>12/12/57</i> PHYSICIAN'S NAME (Type) <i>Dr. S. J. Wainright</i> ADDRESS (Street, city or town, state) <i>Cumberland, Md.</i>		20e. ADDRESS <i>Cumberland, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/14.1957</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Rose Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Cumberland, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Byron Kight</i>		24a. REC'D BY REGISTRAR <i>Dec 13, 1957</i>	
ADDRESS <i>Cumberland, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>John van Strien M.D.</i>	

RECEIVED
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12573

Within corporate limits

12564

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 404 FURNACE STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MICHAEL	Middle JOSEPH	Last LOGSDON	4. DATE OF DEATH DECEMBER 9 1957	Month Day Year	Month Day Year	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MARCH 19 1875	9. AGE (In years last birthday) 82	10. IF UNDER 1 YEAR Months 02	11. IF UNDER 24 HRS. Days 00	12. IF UNDER 24 HRS. Hours 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Oper.		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA	
13. FATHER'S NAME LOGSDON, Peter				14. MOTHER'S MAIDEN NAME Ellen Brannon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 10 872		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.1 DUE TO Tangrene, left leg INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Arteriosclerosis of leg art. " yrs. DUE TO Generalized Arterioscler. " " (c) " "							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 2 1957 to Dec 4 1957 that I last saw the deceased alive on Dec 1 1957 , and that death occurred at 7:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 So. Centre St. Cumberland, Md. DATE SIGNED 12/11/57							
ACTUAL SIGNATURE A. J. Mirkin M.D.							
PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/1957		22c. NAME OF CEMETERY OR CREMATORIUM St. Patricks Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.			
				24a. REGD BY REGISTRAR DATE Dec 12 1957		24b. REGISTRAR'S SIGNATURE John van Strien, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A. M.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the page should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 F 1m0224 1-23-58 et 12574

12565 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORRIGANVILLE		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALBERT		First M.	Middle LOWERY	4. DATE OF DEATH DECEMBER 31	Month 19	Day 57	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE 5, 1899	9. AGE (In years (last birthday) 58 1/2	10. IF UNDER 1 YEAR Months 58	11. IF UNDER 24 HRS Days 1/2	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CORRIGANVILLE, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA	
13. FATHER'S NAME LOWERY, JAMES		14. MOTHER'S MAIDEN NAME WITT, FLORAK		Address CUMBERLAND, MD.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure	
4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Chronic Dilatocardiosis		DUE TO (b) Chronic Bronchitis with Emphysema		DUE TO (c) Bilateral pneumonia one week duration		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hyndman, Pa.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 28, 1957 to Dec 31, 1957 , that I last saw the deceased alive on Dec 31, 1957 , and that death occurred at 3:48 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hyndman, Pa.		DATE SIGNED Jan 1-1958			
ACTUAL SIGNATURE John Topper		PHYSICIAN'S NAME (Type) DR. JOHN TOPPER		22d. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 3, 1958		22b. DATE THEREOF Jan 3, 1958	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey N. Zeigler		ADDRESS Hyndman, Pa.		22c. NAME OF CEMETERY OR CREMATORIUM Porter Cemetery		22d. LOCATION (City, town, or county) Hyndman, Pa. Rd. 1	
				24a. REC'D BY REGISTRAR Hyndman, Pa. Rd. 1		24b. REGISTRAR'S SIGNATURE Hyndman, Pa. Rd. 1	

BUREAU V. A.

JAN 3 1969

RECEIVED

Outside of
Chronic Health Dept.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12575

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie		c. LENGTH OF STAY IN lb 71 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hills Creek Road		d. STREET ADDRESS Hills Creek Road.	
3. NAME OF DECEASED (Type or print) Charles Ellmer		Last Ellmer	4. DATE OF DEATH 1896 Month Dec. Day 15 Year 1957
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Cochills, Pa.		11. AGE (in years— last birthday) 72	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William N. Lowery	
14. MOTHER'S MAIDEN NAME Wassie Brant		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO none		17. INFORMANT sister Myrtle Rider, Ellerslie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH short 2 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour e. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec. 16-1957
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 18-57	22c. NAME OF CEMETERY OR CREMATORIAL Palo Alto Cemetery	22d. LOCATION (City, town, or county) Hyndman (State) Penns.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Butch E. Silcox</i>	ADDRESS 404 Decatur St., Cumberland, Maryland	24a. REGD BY REGISTRAR Dec. 18, 1957	24b. REGISTRAR'S SIGNATURE <i>J. W. Steen, M.D.</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File Pages 1 and 2 with the Board of Health, or if a designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

DEC 19 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12608 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12576

Reg. Dist. No.

Item 13 - 111 - 2-4-1/3/53-16

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation, or disposal.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE i.d.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Winers Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
3. NAME OF DECEASED (Type or print) Harry		First L.	Middle Ludwig
4. DATE OF DEATH Dec. 27		Month Dec.	Day 27
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 1-1973		9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Associated Press, Wash.D.C.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Georgetown, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME E. K. Ludwig		14. MOTHER'S MAIDEN NAME Sibine Glessner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-10-4515A (nicco) Mrs. Jay Cavalier, Frostburg, Md.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 902.0 DUE TO Conditions, If any, which gave rise to immediate cause (b) (c), stating the underlying cause lost.		Shock & generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Sitting in chair, twisted over, fell to floor, fractured		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) right femur.	
20c. TIME OF INJURY 1 Hour p.m. Dec. 21 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) Frostburg, Allegany, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 27-1957 DATE SIGNED	
ACTUAL SIGNATURE H.V. Deming M.D.			
EXAMINER'S NAME (Type) H.V. Deming M.D.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Cremation 12-28-1957		22b. DATE THEREOF J. W. Lee's Son	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R.H. Mattingly Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 12-28-57 New Murray & Da	
		24b. REGISTRAR'S SIGNATURE	

3 A 1000

3 A 1000

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12566 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12577

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE d. Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS Winifred Road.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Raymond	First	Middle	Last
		Lee	McBride
4. DATE OF DEATH Dec. 2	Month	Day	Year 19 57
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 22-1942
9. AGE (In years last birthday) 15 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marvin H. McBride		14. MOTHER'S MAIDEN NAME Neoma Swick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT (father) Marvin McBride, Cumberland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4191 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Laceration of brain(frontal lobe) INTERVAL BETWEEN ONSET AND DEATH 1 hr	
DUE TO (b) Fractured skull			
DUE TO (c) Gunshot wound			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deer hunting, one boy picked up his gun, accidentally went off and the ball hit the McBride boy in head.	
20c. TIME OF INJURY Hour o. m. 9 P.M.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm -near Corriganville, Allegany, Md.
20f. (City or town) Corriganville		(County) Allegany	
(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accidental <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		DATE SIGNED Dec. 2-1957	
EXAMINER'S NAME (Type) H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 5, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Davis Memorial Cemetery		22d. LOCATION (City, town, or county) Cumberland, Maryland. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		ADDRESS	
		24a. REC'D BY REGISTRAR Dec. 4, 1957	
		24b. REGISTRAR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.	

3 'A *Marina*

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12578

12567

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland

b. COUNTY Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL

Cumberland

c. LENGTH OF STAY IN 1b

10/15/57

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Allegany County Infirmary

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9/20/1873

9. AGE (in years
last birthday)

84

10. IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Lonaconing, Maryland

U. S. A.

13. FATHER'S NAME

Leopold Berkenbaugh

14. MOTHER'S MAIDEN NAME

Sarah Rowan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT P.O. Box 599

Address Cumberland, Md.

None

Allegany County Infirmary Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Chronic nephritis

INTERVAL BETWEEN
ONSET AND DEATH

>

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Cerebral arteriosclerosis.

>

Chronic nephritis

>

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
White Nat white
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 10/15/57, 19, to 12/25/57, 19, that I last saw the deceased
alive on 12/24/57, 19, and that death occurred at 10P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

James E. McLean

M.D.

49 Greene St.

12/26/57

PHYSICIAN'S
NAME (Type)

Dr. James E. McLean

Cumberland, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county)
Burial 12/28/57 St. Patricks Cath. Cem. Cumberland, Maryland (State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

John J. Hafer, 12/28/57

John J. Hafer, M.D.

YUHUA V. A.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12579

12568

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 608 Hill Top Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 608 Hill Top Drive				d. STREET ADDRESS 608 Hill Top Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CORA		First	Middle	Last	4. DATE OF DEATH December 25,	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 6, 1877	9. AGE (In years less birthday) 80 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Slanesville, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Wolford				14. MOTHER'S MAIDEN NAME Emile Wolford					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Milton H. Meyers, 608 Hill Top Drive,		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4211 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Coronary Thrombosis Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH None			
						5 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
Dec 25, 1957 19									
21. I certify that I attended the deceased from <u>Dec. 25, 1957</u> , to <u>Dec. 25, 1957</u> , that I last saw the deceased alive on <u>Dec. 20, 1957</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Clay E. Durrett</i>		ADDRESS (Street, city or town, state) Clay E. Durrett, M.D., Cumberland, Md.		DATE SIGNED 12/27/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 27, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		ADDRESS John J. Hafer, Cumberland, Md.		24a. REC'D BY REGISTRAR John J. Hafer, 28, 1957		24b. REGISTRAR'S SIGNATURE John J. Hafer, M.D.			

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FEB 1 1960

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12580

12569 CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in one event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/12/57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. STREET ADDRESS Southern Hotel		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eli	First Eli	Middle 	Last McKenzie
4. DATE OF DEATH December	Month Month	Day 6	Year Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH 1/3/1883
9. AGE (In years lost birthday) 74	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13. FATHER'S NAME Joshua McKenzie	14. MOTHER'S MAIDEN NAME Mary Ellen Alexander		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-10-9881	17. INFORMANT P.O. Box 599 Allegany County Home Records	Address Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.1			
DUE TO Leukemia			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Chronic Appendicitis			
DUE TO (c) General Atherosclerosis			
INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County) (State)
21. I certify that I attended the deceased from 11/12/57 , 19, to 12/6/57 , 19, that I last saw the deceased alive on 12/6/57 , 19, and that death occurred at 8:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St.			
ACTUAL SIGNATURE <i>James E. McLean</i>	DATE SIGNED 12/7/57		
PHYSICIAN'S NAME (Type) Dr. James E. McLean			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/9/1957	22c. NAME OF CEMETERY OR CREMATORIUM St. Michaels Cemetery	22d. LOCATION (City, town, or county) Frostburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR 12/9/1957	24b. REGISTRAR'S SIGNATURE John W. Steen, M.D.

W. J. E. S.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12570 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12581

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE	
Anne Arundel MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b 16 yrs		d. STREET ADDRESS 3251 Virginia Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at the Memorial Hospital		e. RESIDE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Christie John McKinley		4. DATE OF DEATH Dec. 12 1957	Month Year
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7-1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman helper		10b. KIND OF BUSINESS OR INDUSTRY C.O.R.Ly.	
10c. BIRTHPLACE (State or foreign country) Wabash, W. Va.		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William McKinley		14. MOTHER'S MAIDEN NAME Marie Hager	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] no		16. SOCIAL SECURITY NO (wife) Freda McKinley, Cumberland, Md.	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion	
DUE TO Conditions, if any, which gave rise to immediate cause (b) Job, stealing the underlying cause lost.		DUE TO Coronary sclerosis (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. V. Denning M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Dec. 12-1957	
DATE SIGNED			
EXAMINER'S NAME (Type) H. V. Denning M.D.			
22a. BURIAL/CREMATION/REMOVAL (Specify) 12-16-57		22b. DATE THEREOF Burial	
22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarrelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE Dec. 16/57	
		24b. REGISTRAR'S SIGNATURE <i>Ton van Stuiven M.D.</i>	

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Within Corporate Limits
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12571 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Pa.		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockwood		d. STREET ADDRESS Rt. 41	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marlene		First Joy	Middle Miller	Last Miller	4. DATE OF DEATH Dec.	Month Dec.	Year 1957
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 25-1957	9. AGE (In years less birthday) 0 yrs.	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Eversdale, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ray A. Miller		14. MOTHER'S MAIDEN NAME Helen Werner					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT (father) Ray A. Miller, Rockwood, Pa.		Address Rt. 41	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.2		DUE TO		Streptococcus meningitis		INTERVAL BETWEEN ONSET AND DEATH about 14 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Dec. 11-1957			
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 13, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Highland Cemetery		22d. LOCATION (City, town, or county) Garrett, Pa. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Mills & Mickey Funeral Home, Rockwood, Penna.		ADDRESS		24a. REC'D BY REGISTRAR Dec. 12, 1957		24b. REGISTRAR'S SIGNATURE Jan van Strien, M.D.	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12609 CERTIFICATE OF DEATH

12583

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 42 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 338 Front		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
3. NAME OF DECEASED (Type or print) Winifred		First Bernadette	Middle Mills
4. DATE OF DEATH Dec. 12		Month	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Penn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lawrence Donahue	
14. MOTHER'S MAIDEN NAME Bridgett McLarkie		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO		17. INFORMANT John Mills	Address Westernport, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months 10 yrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July - 1, 1957</u> to <u>Dec 12, 1957</u> , that I last saw the deceased alive on <u>Dec 12, 1957</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Piedmont W. Va Piedmont W. Va	
ACTUAL SIGNATURE P. E. Berry		PHYSICIAN'S NAME (Type) P. E. Berry	
22a. BURIAL, CREMATION, BURIAL (Specify) 12/14/57		22b. DATE THEREOF 12/14/57	22c. NAME OF CEMETERY OR CREMATORIUM St. Peters
22d. LOCATION (City, town, or county) Westernport, Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE E. Boral		ADDRESS Westernport, Md.	24a. REC'D BY REGISTRAR DATE 12-14-57
		24b. REGISTRAR'S SIGNATURE John C. Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Y. A. RIVERA



With corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12572

CERTIFICATE OF DEATH

Reg. Dist. No.

12584

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 429 Independence Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) Louis		First Louis	Middle
4. DATE OF DEATH December 21, 1957		Last 	Month
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH November 1, 1878		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Columbia St. School	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Paulus Minnicks	
14. MOTHER'S MAIDEN NAME Margaret Lauterback		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. John Phillips <i>Address</i> Cumberland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Lower limb Esophagitis		INTERVAL BETWEEN ONSET AND DEATH 6 months?	
DUE TO 			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) 			
DUE TO 			
(c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 		(County) 	
		(State) 	
21. I certify that I attended the deceased from 1 Oct 57 , 19 57 , to 21 Dec , 19 57 , that I last saw the deceased alive on 10 Dec 57 , 19 57 , and that death occurred at 9 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 		DATE SIGNED 1/1/58	
ACTUAL SIGNATURE W. Alfred Van Ormer		M.D.	
PHYSICIAN'S NAME (Type) Alfred Van Ormer		MD 122 South Center St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park
22d. LOCATION (City, town, or county) Cumberland, Maryland		(State) 	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR Dec. 26, 1957	24b. REGISTRAR'S SIGNATURE Lowman Shire, M.D.

BUREAU V. A.

DEC 9 1957

REGELV

1 Within corporate limits
STATE
LAW BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12573 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

4 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sacred Heart Hospital

3. NAME OF
DECEASED
(Type or print)

First
John

Middle
William

Last
Murphy

4. DATE
OF
DEATH

Month
Dec.

Day
23
Year
1957

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

male

white

WIDOWED

DIVORCED

June 17-1884

9. AGE (in years
last birthday)

73 yrs

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

12. CIVILIAN CARETAKER

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
yes

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Hospital records.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

trauma-pneu of thorax

INTERVAL BETWEEN
ONSET AND DEATH

4 days

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(b)

lunctured lung (left)

4 days

DUE TO
(c)

fractured 5, 6, 7 ribs post axillary region

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

Fell down cellar steps at home.

20c. TIME OF INJURY
Month, Day, Year

Hour

7-8 p.m.

Dec. 19

1957

20d. INJURY OCCURRED
While at work Not while at work

at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

home

20f. (City or town)

Cumberland

(County)

Allegany, Md.

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

H. V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

Dec. 23-1957

22a. BURIAL, CREMATION, OR
REMOVAL (Specify)

Burial

12/26/57

22b. DATE THEREOF

Hillcrest Burial Park

22d. LOCATION (City, town, or county)

Cumberland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Charles L. George Cumberland, Md.

ADDRESS

24a. REC'D BY REGISTRAR

John van Steen, M.D.

24b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the form PM2 to the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after

VS. ATSM
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BEREAU V. S.

within corporate limits

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or my designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2 57MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12586

Reg. Dist. No. 4

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

12 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

623 Patterson Ave.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
Dec.

10

19

52

5. SEX

female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED DIVORCED

8. DATE OF BIRTH

Oct. 19-1900

9. AGE (In years
last birthday)57
yrs.

10. UNDERTAKER

MONTHS

DAYS

HOURS

M N

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

TOWNSVILLE

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Gallitzien, Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Austin Helsel

14. MOTHER'S MAIDEN NAME

Mary Staun

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Address

(h'sbnd) James Neely, Cumberland, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

Coronary sclerosis

(b) DUE TO
Conditions, if any, which
gave rise to underlying cause
(a), stating the immediate
cause last.

Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour
a. m.
p. m.20d. INJURY OCCURRED
While
at work Not while
20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

H. V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

22a. BURIAL, CREMATION
REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Burial Dec. 13, 1957

Alto Rest Cemetery

Altoona, Pennsylvania

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

George Funeral Home, Cumberland, Maryland.

24a. REC'D BY REGISTRAR

DATE

Dec. 13 1957

24b. REGISTRAR'S SIGNATURE

J. van Straaten, M.D.

BUREAU V. S.

DEC 10 1957

REGELVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12587

12610 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 32 Beall St.		e. STREET ADDRESS 32 Beall St.	
3. NAME OF DECEASED (Type or print) ELIA		First MIDDLE (GUNNETT)	Last 4. DATE OF DEATH DECEMBER 17, 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-1863
9. AGE (In years at birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Gunnett		14. MOTHER'S MAIDEN NAME Catherine Worsing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Miss Virginia Neff, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950, 19, to Dec 17, 1957, that I last saw the deceased alive on Dec 17, 1957, and that death occurred at 900 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) E. Main St.,			
ACTUAL SIGNATURE W. O. McLane, M. D.		DATE SIGNED Dec 19, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-57	
22c. NAME OF CEMETERY OR CREMATORIUM F'bg. Memorial Park		22d. LOCATION (City, town, or county) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE 12-20-57		24b. REGISTRAR'S SIGNATURE Doris Stanley N. Rose	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

DEC 22 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12575 CERTIFICATE OF DEATH

12588

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 13 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY Mineral	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. STREET ADDRESS WILEY FORD		d. STREET ADDRESS WILEY FORD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELTA	Middle VEVA	Last NIELD	4. DATE OF DEATH	Month DECEMBER	Day 21	Year 1957		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH OCTOBER 24, 1913	9. AGE (In years lost birthday) 44 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME RUFUS DORSEY			14. MOTHER'S MAIDEN NAME VEVA SHEETZ						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 472 X <i>Pressure, Vessel</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Topic myoecarditis</i> DUE TO (c) <i>Pulmonary edema</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from 1953 , to 1957 , that I last saw the deceased alive on 21/20 , 1957, and that death occurred at 1:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) George Simons M.D. 728 Union Street Cumberland, Md.									
DATE SIGNED									
ACTUAL SIGNATURE George Simons M.D. 728 Union Street Cumberland, Md.									
PHYSICIAN'S NAME (Type) DR. GEORGE SIMONS		22d. LOCATION (City, town, or county) (State) Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/23/1957	22c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cem.	22d. REC'D BY REGISTRAR Dec. 23, 1957						
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	24b. REGISTRAR'S SIGNATURE George Simons, M.D.						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use of the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1986

12576

CERTIFICATE OF DEATH

12589

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the record or prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 124 Virginia Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ora	First	Middle Lee	Last Nisewarner
4. DATE OF DEATH December	Month	Day 4	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/1891
9. AGE (In years last birthday) 66	10. IF UNDER 1 YEAR Months 06	11. IF UNDER 24 HRS. Days 00	12. IF UNDER 24 HRS. Hours 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Non-work	10b. KIND OF BUSINESS OR INDUSTRY Our Home	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William A. Nisewarner		14. MOTHER'S MAIDEN NAME Emma Rinehart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599, Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
Pulmonary Hypostasis Chronic Myocarditis Cerebral Atrophyclerosis Diabetes Mellitus.			
INTERVAL BETWEEN ONSET AND DEATH 18 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/10/55 , 19, to 12/4/57 , 19, that I last saw the deceased alive on 12/4/57 , 19, and that death occurred at 6:35 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE James E. McLean ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/5/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-57	
22c. NAME OF CEMETERY OR CREMATORIAL Terra Alta Cemetery		22d. LOCATION (City, town, or county) (State) Terra Alta, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarnelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Page 7195		24b. REGISTRAR'S SIGNATURE James F. Scarnelli	

S. A. G. M. S.

320

W. A. G. M. S.

1. **TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

2. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the record prior to burial, cremation, or removal.

VS. AT5ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12577 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Allegany		a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Cumberland		Allegany	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
30 yrs.		Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Sacred Heart Hospital		1403 Arch St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Mollie		Genevieve	Noonan
4. DATE OF DEATH		Month	Day
Dec. 27		Year	1957
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		White	WIDOWED <input checked="" type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days
June 11-1870		7 yrs.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Housewife		Alto, Nevada	
12. CITIZEN OF WHAT COUNTRY?		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Patrick V. King		Maggie Mansfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		None Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		about	
260 x Ureria		1 month	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) Diabetes mellitus		3 years	
DUE TO		or more	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Fractured right femur at surgical neck.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter, nature of injury in Part II of item 1b.) * * * * * Went to the bathroom to wash * * * * * fell to the floor, dizzy spell.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12-27-1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Home		Cumberland Allegany Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		DATE SIGNED Dec. 27-1957	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-57	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) Mt. Savage, Md.	
St. Patrick Cem.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR	
James F. Scarcelli Cumberland, Md.		24b. REGISTRAR'S SIGNATURE <u>Dec. 28, 1957 Jon van Strien, M.D.</u>	

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REFEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12578

CERTIFICATE OF DEATH

12591

Reg. Dist. No. 4

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 24 HRS.	
d. NAME OF HOSPITAL OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) CHARLES		First RICHARD	Middle NUZUM, JR.
Last		4. DATE OF DEATH DECEMBER 25 1957	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH OCTOBER 16, 1945		9. AGE (In years 12 last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pupil		10b. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES R. NUZUM SR		14. MOTHER'S MAIDEN NAME KATHRYN BUCHANAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Charles Nuzum, 810 Mac Donald Terr. Cumberland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		Terminal Bronchial Pneumonia	
DUE TO Cirrhosis liver. (c)		Bronchectasis, bilateral severe	
DUE TO Congenital fibro-cystic disease Pancreas		5 years 3 years some history	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>18 July</u> , 1957, to <u>25 Dec.</u> , 1957, that I last saw the deceased alive on <u>25 Dec. 57</u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>W. Alfred Van Ormer</u>		122 SOUTH CENTRE STREET, CUMBERLAND, MD.	
PHYSICIAN'S NAME (Type) VAN ORMER, ALFRED W.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. DATE THEREOF Dec. 27, 1957	22d. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE: 27/1957	
		24b. REGISTRAR'S SIGNATURE Joe van Strien, M.D.	

REGREV
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DEC 1970

12579

CERTIFICATE OF DEATH

Reg. Dist. No.

12592

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 9 yrs, 8 mo, 9 da.		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE Baltimore Md.		b. COUNTY Allegany		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat Furnace St.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Katherine		First	Middle	Lost	4. DATE OF DEATH 0'Rourke	Month	Day	Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1879		9. AGE (In years lost birthday) 78 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Michael Naughton		14. MOTHER'S MAIDEN NAME Ann Dailey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO.		17. INFORMANT Frank E. Naughton		Address 112 N. Smallwood
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4/20/1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last. (c)		Pulmonary Hypertension.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe psychosis		Chronic Myositis.		?						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 49 Greene St.	(County) Lonaconing	(State) Maryland				
21. I certify that I attended the deceased from <u>Dec. 8th, 1957</u> to <u>Dec. 9th, 1957</u> , that I last saw the deceased alive on <u>Dec. 8th, 1957</u> , and that death occurred at <u>7:45A M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>49 Greene St.</u>		DATE SIGNED <u>12/19/57</u>						
ACTUAL SIGNATURE <u>James E. McLean</u> M.D.		PHYSICIAN'S NAME (Type) Dr. Mc Lean M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 11, 1957	22c. NAME OF CEMETERY OR CREMATORIY St. Mary's Cemetery	22d. LOCATION (City, town, or county) Lonaconing, Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Boal Funeral Home, Westermport, Maryland.		ADDRESS Boal Funeral Home, Westermport, Maryland.	24a. REC'D BY REGISTRAR Dec. 10, 1957		24b. REGISTRAR'S SIGNATURE John T. Boal, M.D.					

BENJAMIN V. S.

DEC 11 1968

REGISTRATION
NUMBER

1 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12580 CERTIFICATE OF DEATH

Reg. Dist. No.

12593

1. PLACE OF DEATH o COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flinstone		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gregory		First	Middle	Last	4. DATE OF DEATH Pifer	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/57	9. AGE (In years last birthday) yrs. 10	IF UNDER 1 YEAR Months 10	IF UNDER 24 HRS. Days 21	Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Jack Pifer				14. MOTHER'S MAIDEN NAME Hazel Van Meter Pifer		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO None		17. INFORMANT Pt. chart					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 292.4		DUE TO Agranulocytosis		INTERVAL BETWEEN ONSET AND DEATH 1 mo.					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Pyelonephritis		(c) Pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH 2 mo.					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pneumonia							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4441 N. Cedar St.		20f. (City or town) Cumberland		(County) Allegany	(State) Md.
21. I certify that I attended the deceased from 12-9 , 19 57 to 12-20 , 19 57 , that I last saw the deceased alive on 12-20 , 19 57 , and that death occurred at 11:40 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE William P. James		M. D. William P. James		ADDRESS (Street, city or town, state) Cumberland, Md.		DATE SIGNED 12-21-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/1957		22c. NAME OF CEMETERY OR CREMATORIUM Glendale Cemetery		22d. LOCATION (City, town, or county) Flintstone, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Dec. 22, 1957		24b. REGISTRAR'S SIGNATURE Tow von Strien, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the certificate.

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BUENAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Within Corporate Limits

12581

CERTIFICATE OF DEATH

12594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 80 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 123 Cumberland, St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) Mary		First Virginia	Middle Reid
4. DATE OF DEATH Dec. 13, 1957	Month 19	Day 13	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Reid Baker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Paul Reid		Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver			
156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day at work <input type="checkbox"/> at work <input type="checkbox"/>	Year 20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 123 Green St	(County) Cumberland	(State) Md.
21. I certify that I attended the deceased from Dec. 10 , 1957 to Dec. 13 , 1957, that I last saw the deceased alive on Dec. 13 , 1957, and that death occurred at 9 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. B. Matthews	ADDRESS (Street, city or town, state) 123 Green St		
PHYSICIAN'S NAME (Type) R. B. Matthews M.D.	DATE SIGNED 12-16-57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/16/57	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.	22d. LOCATION (City, town, or county) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR Dec. 16, 1957	24b. REGISTRAR'S SIGNATURE Tom van Strien M.D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12582 CERTIFICATE OF DEATH

12595
 Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 13 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. STREET ADDRESS 721 SHAWNEE AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First THELMA	Middle VIRGINIA	Last RINEHART
4. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 13 1911
		9. AGE (In years last birthday) 46 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	
11. BIRTHPLACE (State or foreign country) PRESTON CO. W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH B. COLE		14. MOTHER'S MAIDEN NAME LILLIAN WOTRING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Darl Rinehart, 721 Shawnee Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1947, 19, to 23 Dec, 1957, that I last saw the deceased alive on 24 Dec, 1957, and that death occurred at 6:35 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
NAME (Type) Fuller B. Whitworth		DATE SIGNED 26 Dec 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-57	
22c. NAME OF CEMETERY OR CREMATORIAL Carmel Cemetery		22d. LOCATION (City, town, or county) Aurora, WVa.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarcelli		ADDRESS Cumberland, Md.	
24. REC'D BY REGISTRAR 1957-28-1957		24b. REGISTRAR'S SIGNATURE Lowell Strain, M.D.	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12583

CERTIFICATE OF DEATH

12596

Reg. Dist. No. 4

Within corporate limits.

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1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY HAMPSHIRE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALBERT		First MIDDLE TAYLOR		Last RINKER		4. DATE OF DEATH DECEMBER 18		Month Day Year 1957	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 12, 1885		9. AGE (in years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co		11. BIRTHPLACE (State or foreign country) PURGITTSSVILLE, W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME SYLVESTER RINKER				14. MOTHER'S MAIDEN NAME EMMA HIGH					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Ver. no. or unknown) No		16. SOCIAL SECURITY NO. 232-09-0571		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 422.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH One week			
		DUE TO (c)		Arteriosclerotic Cardio Vascular disease		Long time			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) CUMBERLAND, MD.		(County) (State)	
21. I certify that I attended the deceased from <u>12/14/57</u> to <u>12/18/57</u> that I last saw the deceased alive on <u>12/18/57</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Romney, W. Va.		DATE SIGNED 12/19/57			
ACTUAL SIGNATURE DR. W. F. WILLIAMS									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 21/57		22c. NAME OF CEMETERY OR CREMATORIAL Bever Run Cemetery		22d. LOCATION (City, town, or county) Burlington, W. Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Meryl Combs		ADDRESS Romney, W. Va.		24a. REC'D BY REGISTRAR Dec. 20, 1957		24b. REGISTRAR'S SIGNATURE Towson Stein, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate may be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU #6

DEC 23 1977

REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the record or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12584 CERTIFICATE OF DEATH

12597

Reg. Dist. No. 4

1. PLACE OF DEATH o COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) o STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b lyr. 8m. 13da	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. STREET ADDRESS X 3	
3. NAME OF DECEASED (Type or print) Virginia Izora Ryan		First Middle	4. DATE OF DEATH Month Dec. 2 Day 19 Year 57
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Parsons, W.VA.
13. FATHER'S NAME Daniel Corrick		14. MOTHER'S MAIDEN NAME Elousa Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	17. INFORMANT Ray. T. Ryan
		Address Rt. 6, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
Pulmonary Hypertension Chronic Myocarditis Cerebral Arteriosclerosis Senile Psychosis			
INTERVAL BETWEEN ONSET AND DEATH 16 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 20)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 20)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 1953, to <u>Dec. 27, 1957</u> , that I last saw the deceased alive on <u>Dec. 27, 1957</u> , and that death occurred at <u>6 p.m.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>James E. McLean</u> ADDRESS (Street, city or town, state) <u>49 Greene St.</u> DATE SIGNED <u>12/3/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/5/1957	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery
22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight		24a. ADDRESS Cumberland, Md.	24b. REC'D BY REGISTRAR Ray. T. Ryan
		24b. REGISTRAR'S SIGNATURE Ray. T. Ryan	

BULEAU V. S.
DEC 9 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12598

12619 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Borden Mines		c. LENGTH OF STAY IN lb 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Borden Mines, R. D. No 2				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. #2, Frostburg, Md.		d. STREET ADDRESS Frostburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH Schriever	Month	Day	Year
S. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-3-1873		9. AGE (In years last birthday) 84 ^{rs}	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Nathaniel Dunn		14. MOTHER'S MAIDEN NAME Jeannette Neilson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Frank Schriever, R. D. #2, Frostburg,		Address Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		DUE TO <i>arteries</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>				
Conditions, if any, which gave rise to immediate cause (a), slating the under- lying cause lost. b)		DUE TO c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frostburg		(County) (State) Frostburg Md.
21. I certify that I attended the deceased from <u>Nov 27</u> , 1957, to <u>Dec 3</u> , 1957, that I last saw the deceased alive on <u>Nov 27</u> , 1957, and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Frostburg		DATE SIGNED <u>Dec 4</u> , 1957		
ACTUAL SIGNATURE <i>WOM Lane</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>WOM Lane MD</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-5-1957		22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial		22d. LOCATION (City, town, or county) Park		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dean H. M. M. F. G. T. 23</i>		Hafer Fun Express Home		24a. REC'D BY REGISTRAR E. Main		24b. REGISTRAR'S SIGNATURE 12-5-57		<i>Wm. Schriever</i>

BUREAU V. S.

DEC 12 1957

U. S. BUREAU

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Board of Health, or as designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Within corporate limits **12585** MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 16 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at the Memorial Hospital		d. STREET ADDRESS R.F.D. #3	
e. IS RESIDENCE ON A FARM, YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Thornton	Last Sheally
4. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19-1893
9. AGE (In years last b. birthday) 58 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	12. IF UNDER 24 HRS Month Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. car foreman- W. Md. R. Ry.		11. BIRTHPLACE (State or foreign country) Ufalia, Alabama	
13. FATHER'S NAME John B. Sheally		14. MOTHER'S MAIDEN NAME Lelia Beckham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes about 1 month.		16. SOCIAL SECURITY NO (wife) Catrice Sheally, Cumberland, Md.	
17. INFORMANT Address R.F.D. #3			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 400-1 DUE TO Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Coronary sclerosis		?	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 13-1957	
DATE SIGNED			
EXAMINER'S NAME (Type) H. V. Deming M.D.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 15, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE Dec. 16, 1957	
		24b. REGISTRAR'S SIGNATURE John van Straaten, M.D.	

BRUNSWICK V. S.

JEC

100-5400

12620 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegheny CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN McCoole		MARYLAND LENGTH OF STAY (in this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 368 Queen Street		STATE W. Va. COUNTY Mineral CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Keyser STREET ADDRESS 159½ West Piedmont Street	
3. NAME OF DECEASED (First) Edith (Middle) Myrtle (Type or Print) Shears		4. DATE OF DEATH Dec. 11 (Month) 19 (Year) 57	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 31, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 59 yrs.
13. FATHER'S NAME Thomas E. Timbrook		11. BIRTHPLACE (State or foreign country) Romney West Virginia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-07-6875	
17. INFORMANT & ADDRESS Mrs. Pearl Hartman, Keyser W. Va.		14. MOTHER'S MAIDEN NAME Lydia Fout	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Hypertension Cardiovacular Disease unknown</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) Keyser (State) W. Va.
21d. TIME OF INJURY (Month) Dec. (Day) 19 (Year) 57 (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/17/57 to 12/19/57</i> for <i>24 hours</i> to death , and that death occurred at Keyser W. Va. on 12/19/57 , and that I last saw the deceased alive on 11/17/57 , and that death occurred at Keyser W. Va. from the causes and on the date stated above. SIGNATURE <i>Paul Shaly</i> M.D. ADDRESS <i>111 W. Main Street, Keyser W. Va.</i> DATE SIGNED <i>12/14/57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 12/14/57	NAME OF CEMETERY OR CREMATORIUM Queens Point	LOCATION (City, town, or county) (State) Keyser W. Va.
24. REC'D BY REGISTRAR DATE DEC 17 '57	REGISTRAR'S SIGNATURE <i>Del. Shaly</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Rogers Funeral Home Inc., Keyser W. Va.</i>	

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the register within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A

LENORE V. E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12621 CERTIFICATE OF DEATH

12601

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lenaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lenaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Charlestown Street		d. STREET ADDRESS Charlestown Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John	First E.	Middle Shockey	Last December
4. DATE OF DEATH 27	Month 1957	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1876
9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner	10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (State or foreign country) Lenaconing, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Theodore Shockey		14. MOTHER'S MAIDEN NAME Elizabeth Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT John Shockey Jr	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		"Son" INTERVAL BETWEEN ONSET AND DEATH 24 hours	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Congestive Heart Failure (c) DUE TO Arteriosclerosis		1 year Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Dec. 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 27</u> , 19 <u>57</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Leslie R. Miles Jr.</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>12-28-57</u>	
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR.		LONA CONING MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/29/57	22c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery	22d. LOCATION (City, town, or county) Lenaconing, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		24a. REC'D BY REGISTRAR DATE 12/30/57	
ADDRESS Lenaconing, Md.		24b. REGISTRAR'S SIGNATURE Janet M. Beck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this page should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Volume V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then, please remove carbon papers. Page 1 and 2 should be filed with the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12611

CERTIFICATE OF DEATH

12602

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS 91 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 91 Broadway													
3. NAME OF DECEASED (Type or print) J		First LOUIS		Middle SLUSS		4. DATE OF DEATH Dec. 30, 1957		Month Day Year					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-20-1897		9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY State road		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John A. Sluss				14. MOTHER'S MAIDEN NAME Anna Alexander									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-9690		17. INFORMANT Mrs. Margaret Sluss, Frostburg, Md.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebrovascular Disease				INTERVAL BETWEEN ONSET AND DEATH 3 mo							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) E. Main St.,		20f. (City or town) Frostburg, Md.		(County) Frostburg, Md.		(State) Md.			
21. I certify that I attended the deceased from <u>Nov 4</u> , 1957, to <u>Dec 30</u> , 1957, that I last saw the deceased alive on <u>Dec 13</u> , 1957, and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. ACTUAL MEDIUM W. O. McLane												ADDRESS (Street, city or town, state) E. Main St.,	
PHYSICIAN'S NAME (Type) W. O. McLane, M. D.												DATE SIGNED Dec 31, 1957	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-58		22c. NAME OF CEMETERY OR CREMATORIAL F' bg. Memorial Park		22d. LOCATION (City, town, or county) Frostburg, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR 1-2-58		24b. REGISTRAR'S SIGNATURE Nancy Ray							

REGELE V. 2
BUREAU V. 2

JAN 3 1968

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12622

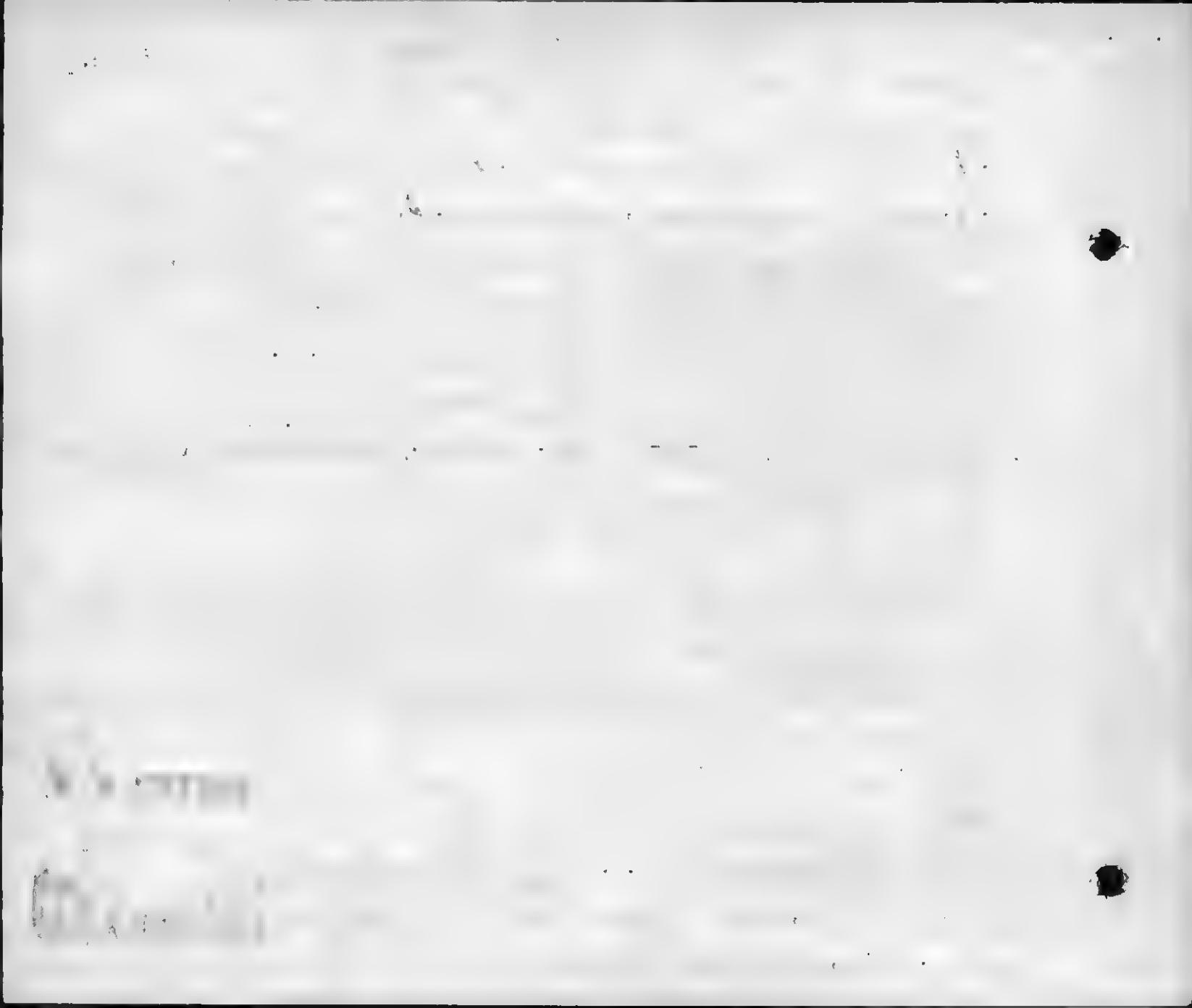
Item 8 File No. 1-8-58 at

12603

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Valley Road, Cumberland		c. LENGTH OF STAY IN 1b 22 yrs		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE X Maryland		b. COUNTY Alegany	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 1, Valley Road, Cumberland, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Valley Road, Cumberland, Maryland		f. STREET ADDRESS Rt. 1, Valley Road, Cumberland		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		h. DATE Month December 28, 1957	
3. NAME OF DECEASED (Type or print) Wilbur		First Wadsworth		Middle Smith		Last		Year 19	
4. SEX Male		5. COLOR OR RACE White		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. B. DATE OF BIRTH January 17, 1893		8. AGE (In years last birthday) 64 yrs.	
9. IF UNDER 1 YEAR Months 0		10. IF UNDER 24 HRS. Days 0		11. HOURS 0		12. MIN. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) Great Cacapon, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Smith		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WV1 705-09-4875		17. INFORMANT Mrs. Thelma H. Smith		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO 4/4		19. ADDRESS Rt. 3, Valley Road	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Cardio renal vascular disease		(b) DUE TO 4 years		(c)		INTERVAL BETWEEN ONSET AND DEATH 2 days			
20a. MEDICAL CERTIFICATION		20c. TIME OF INJURY Month, Day, Year Hour o. m. Sept 19 p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 525 Main Hwy		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 28, 1957 , to Dec 28, 1957 , that I last saw the deceased alive on Dec 28, 1957 , and that death occurred at 1 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Lysle R. Everhart		22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. ADDRESS 12622		24b. DATE Dec 31, 1957		24c. REG'D BY REGISTRAR John J. Hafer, Cumberland, Maryland		24d. REGISTRAR'S SIGNATURE John J. Hafer, Cumberland, Maryland	
VS A15 (4) 1SM 9/55									



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12604

12586 CERTIFICATE OF DEATH

Item 1, Film G224, 1/21/58 Rev

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY ALLEGANY MARYLAND
 CITY (If outside corporate limits, write RURAL
 OR end at nearest town)
 TOWN CUMBERLAND LENGTH OF STAY
 (In this place)
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS 535 N. Mechanic St
 (Daughter's Home)

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE PENNA COUNTY SOMERSET
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN WELLERSBURG
 STREET
 ADDRESS (If rural give location)

3. NAME OF
DECEASED
(Type or Print)Hillie Mae Sturtz4. DATE (Month) (Day) (Year)
Dec. 7, 19575. SEX FEMALE 6. COLOR OR RACE WHITE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) WIDOWED10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) Housewife10b. KIND OF BUSINESS
OR INDUSTRY Housework8. DATE OF BIRTH June 27, 1872 9. AGE last birthday 8511. BIRTHPLACE (State or foreign country) CORRIGANVILLE Maryland12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME

SAMUEL GEARY

14. MOTHER'S MAIDEN NAME

LUCINDA Hiner15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes(Yes, no, or unk.) (If Yes, give war or dates of service)16. SOCIAL SECURITY NO. None17. INFORMANT & ADDRESS Mrs. Florence L. Geary, Cumberland

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

20. INTERVAL BETWEEN
ONSET AND DEATHIMMEDIATE CAUSE Chronic Myocarditis 5 yrs.

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH.

22. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,

OF INJURY street, office, bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month)

(Day)

(Year)

(Hour)

21e. INJURY OCCURRED

M. While at workNot while at work

21f. HOW DID INJURY OCCUR?

VS AISC 1-55 10M

22. I hereby certify that I attended the deceased from Dec. 7, 1957 to Dec. 7, 1957, that I last saw the deceasedalive on Dec. 7, 1957, and that death occurred at 7:30 M, from the causes and on the date stated above.SIGNATURE Hannah L. GearyADDRESS (Street, city, town, state) Hannah L. Geary, Pa.DATE SIGNED 12-9-5723. BURIAL, CREMATION,
REMOVAL (SPECIFY)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

111-220 V. 1

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. AT 5ME
6M 2/57

1
FOR STATE
HEALTH DEPT.

12587 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12605
Reg. Dist. No. 4

1. PLACE OF DEATH o COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE I'd. b COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 16 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 615 Ellwood St	
e. IS RE'D IN I.D. ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alice Lee		First Middle Last	4. DATE OF DEATH Dec. 12 Month Year 1957
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 22-1902		9. AGE (In years last birthday) 55 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress-Johnson		10b. KIND OF BUSINESS OR INDUSTRY Eight Cofeteria	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Clark D. Rinker		14. MOTHER'S MAIDEN NAME Fannie Spates	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 215-20-574 (husband) Edgar L. Swartley, Cumberland, I'd.	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4271 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden about 3 months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE I.V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) I.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 12-1957	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-57	
22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Memorial Pk. Cumberland, I'd.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE Dec. 16, 1957	
		24b. REGISTRAR'S SIGNATURE Fox van Steen M.D.	

SAVANNAH V. S

DEC

100-370

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12588 CERTIFICATE OF DEATH

12606

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		d. STREET ADDRESS Lutrope Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Sophia		First	Middle	Last	4. DATE OF DEATH 12/21/57	Month	Day	Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1879	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME August Tribut		14. MOTHER'S MAIDEN NAME Christine Langholtz							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO None		17. INFORMANT Pt's Chart					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X									
DUE TO Sarcomatous carcinomatosis INTERVAL BETWEEN ONSET AND DEATH 8 mo									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) Fibrosarcoma sterni (c) adenocarcinoma sterni 1 yr.									
DUE TO 1 yr.									
DUE TO 1 yr.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Hour o. m. p. m.		Month Dec.	Doy. 19	Year 1957	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Calvert	(State) Md.
21. I certify that I attended the deceased from 12-10-57, 19 to 12-21-57, 19 , that I last saw the deceased alive on 12-20-57, 19 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Cumberland, Md. (12-21-57)									
DATE SIGNED 12-21-57									
ACTUAL SIGNATURE C. R. Zimmerman, M.D.									
PHYSICIAN'S NAME (Type) C. R. Zimmerman, M.D.									
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23, 1957		22c. NAME OF CEMETERY, OR CEMETORY Rose Hill Cem.		22d. LOCATION (City, town, or county) Cumberland, Md.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lance Stein Inc.		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Dec. 23, 1957		24b. REGISTRAR'S SIGNATURE Jon van Stein, M.D.			

RECEIVED
DECEMBER 3 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**FOR STATE
HEALTH DEPT.**

WITHIN corporate limits
4 should be forwarded to the Chief Medical Examiner's Office along with Form PN3. Page 5 may be retained for your files
TO F. D. R. AL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM
5M 2/57

12589

12607

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admits on) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 2 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 306 N. Mechanic St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
f. STREET ADDRESS 306 N. Mechanic St.		g. S RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Franz		First Franz	Middle John
4. DATE OF DEATH Dec. 24		Month Dec.	Day 24
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> June 16-1889
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired coal miner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franz Dvorah		14. MOTHER'S MAIDEN NAME Marianna Lipa	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 217-14-46291	
17. INFORMANT Daughter, Mrs. Amy Coal		Address rooftop, Ohio	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Coronary occlusion		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 5 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		?	
(b) Coronary sclerosis			
DUE TO Conditions, if any, which gave rise to underlying cause (b), stating the primary cause lost.			
(c) Conditions, if any, which gave rise to primary cause (c), stating the cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Dec. 24-1957	
EXAMINER'S NAME (Type) H. V. Deming M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Dec. 27, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Bayard Cemetery	
22d. LOCATION (City, town, or county) Bayard, West Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR Dec. 26, 1957	
ADDRESS John J. Hafer, Cumberland, Maryland		24b. REGISTRAR'S SIGNATURE John J. Hafer, M.D.	

PIECE/IV/6
BUNNAY X 6

DEC 30 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12612

CERTIFICATE OF DEATH

12608

Reg. Dist. No. 9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		b. COUNTY Allegany		
c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS 35 Maple St.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First SAMUEL	Middle TAYLOR	Last WALKER	
4. DATE OF DEATH	Dec.	Month 4,	Day 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1900	
9. AGE (In years lost birthday) 57 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William B. Walker	14. MOTHER'S MAIDEN NAME Emily Taylor	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT 213-09-6590 Mrs. Samuel Walker, Frostburg, Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of trachea</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Carcinoma of esophagus</i> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour e. m. p. m.	Month 19	Doy Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>Dec. 4</u> , 1957, that I last saw the deceased alive on <u>Dec. 4</u> , 1957, and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md.
ACTUAL SIGNATURE <i>W. E. Gattens</i>				DATE SIGNED 12/6/57
PHYSICIAN'S NAME (Type) W. E. Gattens, M. D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-7-1957	22c. NAME OF CEMETERY OR CREMATORIUM F'bg. Memorial Park	22d. LOCATION (City, town, or county) Frostburg, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 12-7-57	24b. REGISTRAR'S SIGNATURE <i>John Slattery H. Rose</i>	

BUREAU V. S.

DECEMBER 19 1977
FBI - MEMPHIS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12590

CERTIFICATE OF DEATH

12609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		d. STREET ADDRESS Mt. Savage, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Walsh, John Harvey	Middle	Last	4. DATE OF DEATH	Month 12	Day 21	Year 1957
5. SEX	6. COLOR OR RACE male white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-23-1901	9. AGE (In years lost birthday) 56 yrs.	10. IF UNDER 1 YEAR Months 56	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) furloughed		10b. KIND OF BUSINESS OR INDUSTRY Machinist Helper - Chinese Corp. Md.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Walsh		14. MOTHER'S MAIDEN NAME Cora May Walsh					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. 214-03-3355		17. INFORMANT		Address	
Patients chart							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Myocardial Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/21/1957 to 1/21/1957 , that I last saw the deceased alive on 1/21/1957 , and that death occurred at 2:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Leo Ley, M.D.		ADDRESS (Street, city or town, state) 420 N. Center St. DATE SIGNED 1/23/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 24, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Saint Patrick's Cemetery		22d. LOCATION (City, town, or county) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst		ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR Dec. 23, 1957		24b. REGISTRAR'S SIGNATURE John van Steen, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper, - Reg. 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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КЕГЕЛ В. Б

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12613 CERTIFICATE OF DEATH

Reg. Dist. No. 12610

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frostburg</i>		c. LENGTH OF STAY IN 1b <i>40 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frostburg</i>		d. STREET ADDRESS <i>89 Beall St. Extended</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Miners Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Wilton</i> Middle <i>Leonard</i> Last <i>White</i>		4. DATE OF DEATH Dec 5 1957					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Black</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr 18, 1905</i>	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>B & O Railroad</i>		10c. BIRTHPLACE (State or foreign country) <i>Wethersham Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Edward White</i>		14. MOTHER'S MAIDEN NAME <i>Eloise Frazier</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>25-16-4145</i>		17. INFORMANT <i>Mary Ann White - Frostburg Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>441X</i>		DUE TO <i>Cerebral accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i></i>		(b) <i>Malignant Hypertensive Cardiovascular</i>					
DUE TO <i></i>		(c) <i>Disease</i>				4 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan</i> , 1957, to <i>Dec 5</i> , 1957, that I last saw the deceased alive on <i>Dec 5th</i> , 1957, and that death occurred at <i>4:45 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>John B. Davis</i>		DATE SIGNED <i>2 Broadway Frostburg, Md. 12/6/57</i>					
PHYSICIAN'S NAME (Type) <i>John B. Davis, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Dec 9, 1957</i>		22b. DATE THEREOF <i>Dec 9, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Frostburg Memorial Park</i>		22d. LOCATION (City, town, or county) (State) <i>Frostburg Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hafle, Cumberland Md.</i>		ADDRESS <i>12-9-57</i>		24a. REC'D BY REGISTRAR <i>Miss Nancy N. Doe</i>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

FC 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 DPH 201 1-65 at

S.R. W.F. WMS.

12591

CERTIFICATE OF DEATH

12611

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please receive carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE WEST VIRGINIA		b. COUNTY Hampshire				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT ASHBY						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS Fort Ashby		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) SUSIE		First	Middle	Lost	4. DATE OF DEATH WILLISON	Month	Day	Year		
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 1/11 1891	9. AGE (In years last birthday) 89 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Fort Ashby, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME GIBSON PYLES				14. MOTHER'S MAIDEN NAME MOLLIE BERRY						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-6430		17. INFORMANT Mrs. Insurance Alkire		Address Fort Ashby, W. Va.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 5 days. Cerebral Hemorrhage Generalized Arteriosclerosis Diabetes Mellitus										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Fort Ashby		(County) W. Va.	(State) W. Va.	
21. I certify that I attended the deceased from 12-19-57 to 12-23-57 that I last saw the deceased alive on 12-22-57 , and that death occurred at 12:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Dr. J. Williams, M.D.									ADDRESS (Street, city or town, state) Numbered Lane, Fort Ashby, W. Va.	DATE SIGNED 12/23/57
22e. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22b. DATE THEREOF 12-26-57		22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		22d. LOCATION (City, town, or county) Fort Ashby, W. Va.		(State) W. Va.		
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-57		22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		22d. LOCATION (City, town, or county) Fort Ashby, W. Va.		(State) W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarelli, Cumberland, d.		ADDRESS		24a. REC'D BY REGISTRAR Dec. 26, 1957		24b. REGISTRAR'S SIGNATURE John van Strien, M.D.				

REGEAU V. S.
REGEAU V. S.

DEC

W. MD. STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12612

Reg. Dist. No. 4

1259

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before adm is on) a. STATE Md.		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 629 Henderson Blvd.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 629 Henderson Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Henry		First	Middle	Last	4. DATE OF DEATH Dec. 15 1957	Month	Day	Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17-1892	9. AGE (in years last birthday) 65 yrs	10. IF UNDER 18 YEARS Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done) Bartender - Cumberland Brewing Co.		10b. KIND OF BUSINESS OR INDUSTRY Cumberland Brewing Co.		11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Stewart Winebrenner		14. MOTHER'S MAIDEN NAME Mary Sophia Winebrenner						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes.		16. SOCIAL SECURITY NO W.V.I		17. INFORMANT Helen Twiggs Winebrenner, Cumberland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Exhaustion & Malnutrition		19. INTERVAL BETWEEN ONSET AND DEATH gradual				
153X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Carcinoma of cecum colon with metastasis		4-5 months.				
DUE TO (c) to abdominal organs.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE H. V. Denning M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) H. V. Denning M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Dec. 15-1957				
22a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify) Burial		22b. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22c. LOCATION (City, town, or county) Cumberland, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Date 18/1957		24b. REGISTRAR'S SIGNATURE J. van Strien, M.D.		

TUREAU V. S.

DEC 20 1977

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FOR STATE
HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or the designated agent, prior to burial, cremation, or removal. Send in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

12614 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 1-3-58		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Allegany	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Centennial Ave. Ext.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		f. STREET ADDRESS Centennial Ave. Ext.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank		First R.		Middle Winner		4. DATE OF DEATH Dec. 31		Month Year 1957	
5. SEX a. Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 31-12-1904		9. AGE (in years last birthday) 73 yrs		10. IF UNDER 14 YEARS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) a. Salvage Dept. Celanese Corp.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harmon Winner		14. MOTHER'S MAIDEN NAME Laura Crowe							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 220-10-2723 (soc. sec. card, Raymond Winner, Frostburg, Md.)		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)		Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH and 120			
		Arteriosclerotic heart disease. In ut 11 yrs. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL H. V. Domning M.D.						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Dec. 31-1957		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Domning									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-3-58		22c. NAME OF CEMETERY OR CREMATORIUM F'bg. Memorial Park		22d. LOCATION (City, town, or county) Frostburg, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		ADDRESS JAN		24a. REC'D BY REGISTRAR JAN		24b. REGISTRAR'S SIGNATURE Perry			

RECEIVED
BUREAU W. A.

JAN 3 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12593

CERTIFICATE OF DEATH

12614

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		c. LENGTH OF STAY IN 1b 3 days 7 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 1026 Kent Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sanford Hospital, W. M. R. R.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Carl Wisegarver, Sr.		First	Middle	Losi	4. DATE OF DEATH 12/8/57	Month	Day	Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/82	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired W.M.R.R. Train Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY Penna.		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Wisegarver		14. MOTHER'S MAIDEN NAME Elizabeth Drellinger							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 705-10-6046		17. INFORMANT Family Alert		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) IX		DUE TO BRONCHOPNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 2 days 48 hrs					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CEREBRAL INFARCTION - RIGHT				5 days					
(c) CEREBRAL HEMORRHAGE - RIGHT				5 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROSIS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) 59 GREENE ST		20f. (City or town) CUMBERLAND, MD		(County) 59 GREENE ST	(State) CUMBERLAND, MD
21. I certify that I attended the deceased from 12/7/57 , 19 57 , to 12/8/57 , 19 57 , that I last saw the deceased alive on 12/7/57 , 19 57 , and that death occurred at 945 PM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 59 GREENE ST		DATE SIGNED 12/8/57			
ACTUAL SIGNATURE Allegany		M.D.							
PHYSICIAN'S NAME (Type) S G WEISMAN MD									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/57		22c. NAME OF CEMETERY OR CREMATORIUM Everett Cemetery		22d. LOCATION (City, town, or county) Everett, Penna.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Dec. 9, 1957		24b. REGISTRAR'S SIGNATURE John W. Shirey, M.D.			

BRUNSWICK

DEC

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12594

CERTIFICATE OF DEATH

12615

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 33 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 6 ALTAMONT TERRACE				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) RUSSELL		First Howard	Middle 	Last WITHERS	4. DATE OF DEATH DECEMBER 19	Month 	Day 	Year 1957		
5. SEX MATE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 6, 1909	9. AGE (In years last birthday) 48	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS. Days 	12. IF UNDER 24 HRS. Hours 	13. CITIZEN OF WHAT COUNTRY? USA		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? Cumberland				
13. FATHER'S NAME WILLIAM WITHERS (DECEASED)		14. MOTHER'S MAIDEN NAME MARTHA SWADLEY				Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 705-05-4588		17. INFORMANT PT'S CHART		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis with Decongestion / Onset 4-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 1 month		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5:00 ADDRESS (Street) city or town, state		20e. (City or town) Cumberland, Md	(County) 	(State) 12-20-57
21. I certify that I attended the deceased from 11-18-57 to 11-19-57 that I last saw the deceased alive on 11-18-57 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.		ACTUAL SIGNATURE J. T. Johnson, Jr.		M.D.		DATE SIGNED 12-20-57				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-57		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Dec. 21, 1957		24b. REGISTRAR'S SIGNATURE Ton van Strien, M.D.				

PUINÉAU A. &
DECEMBER 3 1957

Within corporate limits.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12595

Item 9 File G223 12-26-57 et

Reg. No. 126164

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Old Town x2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Charles	Middle Franklin	Last Witt	4. DATE OF DEATH Month Dec. 10 Day Year 19 57
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 18-1889	9. AGE (In years last birthday) 67 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired coal miner & Trackman - B&O.R.Ry.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.	
13. FATHER'S NAME Charles Edward Witt		14. MOTHER'S MAIDEN NAME Alcindia Norris		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. I.W.W.I 220-10-1799		17. INFORMANT (nephew) Charles Witt	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last.		Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH sudden	
DUE TO (b) Coronary sclerosis				?	
DUE TO (c) Arteriosclerosis				?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Dec. 11-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 13, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Maryland.		ADDRESS		24a. REC'D BY REGISTRAR 126164, 12, 1957	
				24b. REGISTRAR'S SIGNATURE J. van Strien, M.D.	

BUREAU V. S.

DEC 16 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

12596

CERTIFICATE OF DEATH

12617

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 85 yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 34 Boone St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
3. NAME OF DECEASED (Type or print) Ella		First E.	Middle Yost			
4. DATE OF DEATH Dec. 13	Month Dec.	Day 13	Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1868			
9. AGE (In years lost birthday) 89 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home				
11. BIRTHPLACE (State or foreign country) Orleans, Md.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William Clay		14. MOTHER'S MAIDEN NAME Mary Ann Fitzpatrick				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None				
17. INFORMANT Mrs. Emil Krampf, Cumberland, Md.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 days Arterosclerosis 10 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.	20f. (City or town) 236 W. Vir. Cumberland	(County)	(State)
21. I certify that I attended the deceased from <u>Dec. 12</u> , 1957, to <u>Dec. 13</u> , 1957, that I last saw the deceased alive on <u>Dec. 13</u> , 1957, and that death occurred at <u>M.D.</u> from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Clay E. Durrett</i>		ADDRESS (Street, city or town, state) 236 W. Vir. Cumberland, Md.				
PHYSICIAN'S NAME (Type) Clay E. Durrett		DATE SIGNED 12/13/1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-17-57		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE Dec. 16, 1957	24b. REGISTRAR'S SIGNATURE John van Strien, M.D.	

DEPARTMENT OF DEFENSE
CERIFICATE OF DEATH

BUREAU V.

DEC 18 1957

RECEIVED